Defendants. )

THE DEPOSITION OF RANDALL E. MARCUS, M.D. WEDNESDAY, JULY **14, 1999** 

The deposition of RANDALL E. MARCUS, M.D., called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Robert J. Wanous, Notary Public within and for the State of Ohio, taken at the University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, Ohio, commencing at 2:10 p.m., the day and date above set forth.

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## **CADY & WANOUS REPORTING SERVICES, IN(** 55 PUBLIC SQUARE 1225 ILLUMINATING BUILDING CLEVELAND, OHIO 44113 (216) 861-9270

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2	APPEARANCES:
3	On behalf <b>of</b> the Plaintiff:
4	Justin F. Madden, <b>Esq.</b> Spangenberg, Shibley & Liber
5	2400 National City Center Cleveland, Ohio <b>44114</b>
6	
7	On behalf of the Defendant Dr. Ghanma:
8	John D. Travis, Esq. Gallagher, Sharp, Fulton & Norman
9	7th Floor Bulkley Building Cleveland, Ohio <b>44115</b>
10	On behalf of the Defendant Dr. Quansah:
11	Dennis R. Fogarty, Esq.
12	Weston, Hurd, Fallon, Paisley & Howley 2500 Terminal Tower
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14	On behalf of the Defendant Lorain Community:
15	Patricia Casey Cuthbertson, Esq. Moscarino & Treu, LLP
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2	DEPOSITION INDEX RANDALL E. MARCUS, M	.D.
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1		RANDALL A. MARCUS, M.D.
2		of lawful age, called by the Plaintiff for
3		examination, pursuant to the Ohio Rules of Civil
4		Procedure, having been first duly sworn, as
5		hereinafter certified, was examined and
6		testified as follows:
7		EXAMINATION OF RANDALL E. MARCUS, M.D.
8	BY MR.	MADDEN :
9	Q	Good afternoon, sir. Would you do us the
10		formality of stating your full name, please.
11	A	Randall Evan Marcus.
12	Q	What do you do for a living, sir?
13	A	I am an orthopedic surgeon.
14	Q	Dr. Marcus, I am Justin Madden and you and ${\tt I}$
15		just met before the deposition. Thank you for
16		your time this afternoon. This is our
17		opportunity, in representing the estate of Brad
18		Porter, to take a discovery deposition from you
19		and ascertain what it is that you have by way of
20		opinions and testimony in this case.
21		Now, I am going to have a number of
22		questions, and if some of them don't make sense,
23		they may not, please point that out so I can
24		make sure when you answer you do understand a
25		question clearly. Is that fair?

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1	A	Yes.	
2	Q	Doctor, what is your professional address?	
3	Α	Department of Orthopedic Surgery, Case Western	
4		Reserve University School of Medicine,	
5		University Hospitals, <b>11100</b> Euclid Avenue,	
6		Cleveland, Ohio <b>44106.</b>	
7	Q	And you have a copy of your curriculum vitae.	
8		<b>Is</b> that a current copy?	
9	А	As of February, <b>1999,</b> it is.	
10	Q	Can we go ahead and mark that copy, sir?	
11	A	Yes.	
12	Q	Okay.	
13		[Deposition Exhibit 1 was marked.]	
14	Q	Handing you what has been marked Plaintiff's	
15		Exhibit 1, Doctor, can you identify this as a	
16		current curriculum vitae as of February of this	
i7		year?	
18	A	Correct, yes.	
19	Q	Can you tell by looking through it if there are	
20		any articles, honors, societies that you	
21		currently have or know of that do not appear in	
22		Plaintiff's Exhibit 1?	
23	A	I have given some talks since February, 1999,	
24		that are not in here yet. And I may have	
25		published a paper. ${f I}$ will have to check, that	

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6 hasn't been in here. 1 2 0 The talks -- or the paper that you have referenced, Doctor, do you recall if the subject 3 of any of those talks or papers dealt with 4 5 treating trauma patients? They would definitely, they would most likely 6 Α 7 deal with treating trauma patients. All right. If you would be kind enough to let 8 0 Mr. Travis know if you have any copies of the 9 articles or if you have the title and location 10 of the presentations. We would **all** be 11 interested in seeing what those entail. 12 13 Doctor, let me take **a** minute to look 14 through here. You are board certified in what 15 medical speciality, sir? 16 Α Orthopedic surgery. There is no board certification for trauma 17 0 18 surgery; is that correct? Within orthopedic surgery? 19 Α Well, is there a certification, a board 20 Q 21 certification in trauma surgery, just as a 22 speciality? Not that I know of. 23 Α 24 0 Okay. Do you have experience or training in handling trauma patients? 25

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1	А	Yes.
2	Q	Okay. Can you tell me a little bit about that?
3	А	Well, a large part of orthopedic surgery is the
4		treatment of traumatic injuries, meaning,
5		somewhat redundant, but fractures and injuries
6		that occur because of traumatic problems. Part
7		of our training is in trauma and my
8		subspeciality, one of my subspeciality areas, is
9		in the area of trauma.
10	Q	Okay. As far as the subspeciality, did you
11		attain any course or receive any type of
12		certification for that subspeciality?
13	Α	Yes. I did three fellowships after I finished
14		my orthopedic surgical residency here at Case
15		Western Reserve in orthopedic trauma.
16	Q	All right. A patient such as Brad Porter,
17		presenting with the symptoms with which he
18		presented back on July 13th, is that a pat-ient
19		that you would typically handle in your
20		professional practice?
21	А	Yes. I didn't quite finish answering the
22		question before that, Justin.
23	Q	Go ahead, I am sorry.
24	А	Sorry. I have also been elected into the
25		Orthopedic Trauma Association.

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1	Q	Thanks for pointing that out.
2		MR. TRAVIS: Are you done
3		now? You were going to say something.
4		THE WITNESS: Yes. Well, I
5		believe Justin's question was subspecialization
б		in trauma.
7		MR. TRAVIS: Yes.
8		THE WITNESS: And I was
9		elected to the Orthopedic Trauma Association in
10		1986. And I was elected into the Societe
11		Internationale De Chirurgie Orthopaedique Et De
12		Traumatologie, which is called SICOT, which is
13		the International Trauma Association, in <b>1991.</b>
14		Again, both of those organizations are not
15		things you apply for until you are elected into,
16		based on your trauma credentials. I have also
17		published quite a few papers, as you can see.
18		Now, your next question is what?
19	Q	My next question was: A patient such as Brad
20		Porter, if he presented to this hospital, is he
2 1		a patient that you would typically treat in your
22		professional practice?
23	A	Yes.
24	Q	Okay. A large part of your practice is in the
25		elective surgeries of prosthetic devices for

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1		knees and hips; is that true?	
2	A	That's true.	
3	Q	And can you quantify, in terms of percentage,	
4		what part of your practice is devoted to that	
5		elective surgery, as opposed to trauma patient	
6		care?	
7	A	Yes, to some extent. As you know, trauma	
8		patient care is sort of unscheduled care. So	
9		those of us who deal in trauma all have other	
10		subspecialties that we do our elective surgery	
11		in. My elective surgery is in lower extremity	
12		problems, as you mentioned, Justin, surgery of	
13		the hip, surgery of the knee, surgery of the	
14		foot and ankle as well. $I$ would say probably	
15		most of my elective time is, my scheduled time,	
16		is taken up with elective surgeries, such as	
17		reconstructive problems, which would include	
18		reconstruction following severe trauma. Acute	
19		trauma injuries probably only taking maybe 20	
20		percent of my time. Those tend to be emergency	
2 1		type problems that ${\tt I}$ would handle, either	
22		because of I am on call, or one of my associate	S
23		who is on call has a specific trauma problem in	L
24		the lower extremities that he might refer to me	•
25	Q	Okay. So I think what you are telling me, and	
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1		if <b>I</b> misstate this, point this out, about 80
2		percent of your professional practice is devoted
3		to elective surgeries, perhaps 20 percent,
4		although ${\tt I}$ am sure it fluctuates because it is
5		unpredictable, deals with trauma patients?
6	Α	That <b>is</b> correct. Probably more trauma in the
7		summer than in the winter.
а	Q	Okay. And you are also on the faculty here at
9		Case Western?
10	Α	I am.
11	Q	What percentage of your time is devoted to
12		teaching or can you tell me a little bit about
13		your faculty responsibilities?
14	A	I am a professor of orthopedics at Case Western
15		Reserve University Medical School. So I am
16		constantly teaching. I have residents assigned
17		to my service. Most of my teaching is in the
18		post doctoral area, meaning people that have
19		already received their medical degree that are
20		becoming orthopedic surgeons. <i>So</i> you might say
21		I am always teaching to some extent, because ${f I}$
22		have a resident with me. I am probably asked to
23		give one to two lectures to the undergraduate
24		medical students per year.
25		MR. MADDEN: Okay. Let's go

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1		off the record.
2		[Discussion had off the record.]
3	Q	<i>Go</i> ahead back on.
4		Dr. Marcus, ${\tt I}$ was looking through the list
5		of publications in your <b>CV.</b> Are there any
6		publications, to your memory, and please feel
7		free to look through these, that you feel deal
8		with the kind of subject matter that we have in
9 -		this particular patient's case?
10	A	Justin, that is a tough question to answer. As
11		you know, most of them have to do with trauma
12		and this is a traumatic case. None of them that
13		I recall have anything to do with liver
14		lacerations, or specifically they are all from
15		an orthopedic point of view.
16	Q	All right. So we are dealing more, in your
17		published articles, you are really talking about
18		traumatic injuries resulting in broken bones or
19		fractures?
20	A	For the most part. There is a paper that was
21		published in the Journal of Bone and Joint
22		Surgery on multiple injury in children, that
23		might have something to do with this. And ${ t I}$
24		have a textbook that ${\tt I}$ edited on the multiply
25		injured child. But again most of these papers

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1		are from the point of view, the orthopedic point
2		of view.
3	Q	All right. The presentation in the article that
4		you mentioned does not appear in here. Do
5		either of those, to your memory, deal with any
6		sort of trauma discussion to the abdominal area?
7	A	No.
8	Q	Let me go ahead and ask you about how you are
9		being compensated for your professional time in
10		this case, break it down for me?
11	А	Yes. Our group charges per hour of time,
12		regardless of what we are doing, whether it is
13		depositions or reviewing records. It is \$500
14		per hour.
15	Q	All right. And the same is true with trial
16		testimony?
17	А	Exactly.
18	Q	<b>Is</b> it your intention to testify live at the
19		trial, if this matter goes that far?
20	А	If it can be worked into my schedule.
2 1	Q	Have you served as an expert in cases such as
22		this, not as a treating physician but as a
23		liability expert in the past?
24	А	A case such as this?
25	Q	Well, let me rephrase that. Putting aside,

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		putting aside testifying as a treating physician
N		in the damage portion of a case, have you
m		testified before as an expert on the issue of
4		liability, either on behalf of the patient or on
ы		behalf of a defendant doctor?
9	А	Yes.
2	Q	How many times in total?
ω	А	Testify in court?
<u>ס</u>	Ø	Serving as an expert.
10	A	Oh, in my career, a lot of times.
н Н	Q	I know it is not something everybody keeps trac <b>x</b>
12		of.
13	A	Right.
14	α	But 15, 25 times as a liability expert?
ы П	A	Yes, I would say that.
16	Ø	And that is over the course of your career?
1 J	A	Right. There are some years that I haven't
18		reviewed or testified at all and other years I
19		will have a couple of cases.
20	O	In your service as an expert on the issue of
21		whether a doctor met or violated the standarD of
22		care, have you ever testified on behalf of a
23		plaintiff against a physician?
24	A	Yes.
25	Ø	Of the 25 times or so that we talked about, what

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1		percentage or how many times for <b>a</b> plaintiff?
2		MR. TRAVIS: Objection. The
3		numbers are 15 or 25. You can answer, Doctor.
4	Α	Yes. I do not keep track <b>of</b> those numbers. But
5		if testifying means reviewing cases, I would say
6		over I have been in practice since <b>1981,</b> it
7		is probably more than 25 times. But I would say
8		as an estimate, that probably two-thirds of the
9		cases that I review are for defending the
10		physician and probably one-third for the
11		plaintiff, the patient.
12	Q	Okay. I appreciate that.
13		And if the case moves beyond the reviewing
14		stage and you actually give ${f a}$ deposition or
15		testify in trial, is it about the same
16		breakdown, two-thirds for the defendant,
17		one-third for the plaintiff?
18	A	I would say roughly, yes, that probably makes
19		sense. That would be true.
20	Q	Okay. <b>So</b> understanding that you have reviewed a
2 1		lot of cases, some of which may not really be
22		involved later in a deposition or a trial, when
23		you said 15 to 25 cases you are referencing
24		where you have actually given a deposition or
25		testified in court, is that fair?

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Н	A	Yes, I would say at least that. Right.
2	O	Have you ever worked with Mr. Travis on a case
m		before?
4	A	No.
ഹ	Ø	All right. Originally you were retained by the
9		Jacobson Law Firm and Don Switzer?
7	A	Yes, I believe that is true.
ω	Ø	How many cases did you have with the law firm of
σ		Jacobson-Maynard in regard to your recollection?
10	A	I don't know the exact number, but I reviewed a
г г		number of cases, a lot of cases for them, I
12		would say.
13	Ø	All right. And would they have comprised the
14		bulk of your involvement in the cases where you
1 2 1		actually gave a deposition or testified in trial
16		for the defendant?
17	А	I don't know. A number of cases that I reviewed
18		for them and for other attorneys, I guess $\cdot I$
19		would come up with answers they didn't like, so
20		I would never hear from them again.
21	Q	In the cases where you have actually testified
22		in a deposition or at trial and you were serving
23		as a liability expert for the plaintiff, those
24		were cases where you would have said some
25		physician or some medical provider failed to

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1		meet a standard of care, is that fair?
2	А	There were cases like that, yes.
3	Q	And in those cases, did any of them involve
4		trauma care, patients who had a blunt trauma of
5		some type and you felt the physicians did not
6		meet the standard <b>of</b> care?
7	Α	Justin, when you say blunt trauma, you mean like
8		blunt trauma to the abdomen?
9	Q	Let's go with that.
10	Α	As opposed to the bones.
11	Q	Let's just say specifically with blunt trauma to
12		the abdomen?
13	Α	I don't recall any of them having anything to do
14		with blunt trauma to the abdomen.
15	Q	Okay. Now, you had indicated you and Mr. Travis
is		met about ten days ago to schedule your
17		deposition and so forth. What comprises your
18		file, if I might look through it for a moment?
19	A	Yes. The important part of my file is here. $ t I$
20		also have with me the autopsy information. What
2 1		I did not bring are all the depositions and all
22		the expert reports that Mr. Travis has provided
23		me with.
24	Q	Okay. And I understand why, there is ${f a}$ lot.
25	A	It is a whole carton full.

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1	Q	In your report, you have actually broken down
2		for us well, before I get there you have
3		written a report in this case, correct?
4	A	Yes.
5	Q	A report dated July 7th '97?
6	A	Yes.
7	Q	Had you written any reports to Mr. Switzer prior
8		to that date?
9		MR. TRAVIS: On this case?
10		MR. MADDEN: Yes, sir.
11	A	Not no.
12	Q	Have you written any sort of follow-up report or
13		have you had any communication with Mr. Travis
14		regarding your opinions in this case with
15		respect to written communication?
16	Α	I have had no written communication regarding
17		any reports with him.
18	Q	So what we have dated July 7th '97 is the only
19		report outlining your opinions concerning this
20		case?
21	A	That's correct.
22	Q	Now, you have broken down that you have reviewed
23		the following, and that includes the medical
24		records for Mr. Porter, autopsy photographs,
25		deposition transcripts of Drs. Ghanma, Salka,

1 f

18 1 Quansah, Onyekwere, Mr. Porter, Mrs. Porter, medical reports from Dr. Shapiro and Klein, the 2 report from the Ohio Division of Watercraft 3 boating accident, the medical report of Dr. 4 Bonnell and the medical records of Dr. Ghanma? 5 6 Α Right. 7 0 To your knowledge, have you reviewed anything else that doesn't appear in this particular 8 summary? 9 As you can see, that report was written to 10 Α Yes. Mr. Switzer in July of 1997. And I didn't hear 11 12 anything more about this case until 1999, when I 13 believe, when Mr. Travis called me to tell me that he was now involved in the case and wanted 14 to know if I would be willing to continue in the 15 case and work to review materials from him. 16 And 17 so I said yes. And I have since reviewed more materials. 18 Can you tell me what additional materials you 0 19 have reviewed? 20 If you can give me back my report. 21 Α Yes. Q Yes, sure. Absolutely. 22 Off the record. 23 MR. TRAVIS: 24 [Discussion had off the record.] 25 Α Back on the record. I have reviewed -- may I

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19 just tell you everything that I have reviewed. 1 2 0 Yes, please. Rather than go back and forth. 3 Α The Lorain 4 Community St. Joseph Regional Health Center admission 7-13-95 to 7-15-95. The Division of 5 Watercraft boating accident report, deposition 6 7 of Mr. Porter and Mrs. Porter, deposition of 8 Mark Shapiro. Expert reports of Mark Shapiro and E.F. Klein. Deposition of Dr. Ghanma, Dr. 9 Quansah, Dr. Salka, Dr. Onyekwere, and Dr. 10 O'Day. Deposition of Dr. Bonnell, defense 11 12 expert reports of Dr. Bonnell, Dr. McAuley, Dr. 13 Kirkwood, Dr. Sydulka, Dr. Zumwalt, Dr. Raab, Dr. Hershman, Dr. Hoffman. Autopsy report and 14 photographs. Death certificate. Pictures of 15 anesthesia equipment. To my knowledge, that is 16 17 all. 18 MR. TRAVIS: And the recent depositions. 19 Hold on. Off the record. Α Yes. 20 21 Yes, I got it. I also reviewed 22 depositions of Dr. McAuley, Dr. Zumwalt, and Dr. 23 Bonnell. 24 MR. TRAVIS: You said 25 Bonnell. Matus is currently, the most recent

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1		one.
2		THE WITNESS: And Matus and
3		Daniels.
4	Q	And you are aware that Dr. Ghanma has been
5		deposed twice? He had a supplemental deposition
6		about a year after his first one. $\  \  \mathbf I$ just wanted
7		to make sure you have seen that.
8	A	Yes, I believe I saw that.
9	Q	All right. Are you all set?
10	A	All set.
11	Q	So we have a number of rather thick documents
12		that you have reviewed. They are not here, but
13		we know what they are and that is good.
14		Now, I also have in front <b>of</b> me the
15		photographs from the autopsy, correct?
16	A	And the autopsy report, I believe.
17	Q	And the autopsy report follows. Why don't you
18		just go ahead and tell me what that packet
19		entails?
20	A	This <b>is</b> a packet that was given to me by Mr.
21		Travis. It is autopsy photographs,
22		MR. TRAVIS: If I can
23		interrupt, these are just deposition exhibits
24		from the coroner's deposition.
25	A	That <b>is</b> exactly what they are.

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21	Q hll right Xawm rou rwwimwmu any mepical	litpraturp in coming to your opinions in t <b>&gt;</b> is	casp_any spwcific articlps, journals?	A No *	Q Yo_ rwgularly reaw mewical litwraturw, I woulw	assume?	A Yes.	Q What sorts of literature Do you receive and	Aprise on a regular Dasis?	A I read the Journal of Done and Joint Surgery I	rゅap t <b>A</b> ∞ jou≂nal of th¤ <b>h</b> merican Acap⊮my of	Orthopphic Zyrgrons, I real the journal of the	orttopropic Tr uma Association Clinical	ort <b>bop</b> pdics and rplatpd rplarcy rpgularly	D Xawm you pargonally spoke with any physician or	nerep of Appical provider eto eas incolept in	treating Mr. Porter?	A No I <b>h</b> awen't	Q To the extent that you have hap any contact in	this casp. I asswme it is withwr from Ar.	Switz¤r any <b>h</b> is of≷ic¤ or Hr. Mrawis any <b>h</b> is	o≲fice; is %h∃t fair?	A Correct.	Q Do you haw¤ any information you can t ink o≤	in this casp that was not part of your filp or	
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1		 provided to you either <b>by Mr.</b> Switzer or by Mr.
2		Travis?
3	A	None.
4	Q	Now, I want to cover <b>a</b> few areas. And if there
5		is something to talk about, fine, but ${\tt I}$ think we
6		are going to be moving towards the second
7		debridement surgery.
8		Let me ask you, first of all, you are
9		aware from reading the watercraft division
10		report the basic facts surrounding Mr. Porter's
11		incident in Lake Erie on July 13th?
12	А	Yes.
13	Q	And you are aware that there were some rescue
14		efforts made by professionals and laypersons in
15		getting him from Lake Erie over to the hospital?
16		Do you have any criticisms <b>of</b> anybody involved
17		in providing rescue care?
18	A	No.
19	Q	Dr. Ghanma testified that he believed the liver
20		laceration, the abdominal injuries, were
21		sustained while Mr. Porter was in Lake Erie. Do
22		you agree with that?
23		MR. TRAVIS: Objection. I
24		would like you to refer to particularly where
25		Dr. Ghanma said that.

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1	Q	Let me ask you as a general proposition, do you
2		have an opinion where Mr. Porter may have
3		sustained his liver laceration?
4	A	Yes.
5	Q	And where is that, sir?
6	A	In the operating room.
7	Q	Okay. Do you believe that Mr. Porter sustained
8		any abdominal injuries while he was in Lake Erie
9		and prior to arriving at the hospital?
10	A	I have an opinion, <i>yes</i> .
11	Q	Okay. What is the opinion?
12	Α	That he did not sustain any significant injuries
13		to his abdomen, intraabdominal organs, while in
14		Lake Erie.
15	Q	Can you tell me what your understanding is of
16		Mr. Porter's episode in Lake Erie prior to
17		coming to the hospital?
18	A	To the best of my recollection, he was involved
19		in a storm that caused his boat to sink. And in
20		an attempt to rescue Mr. Porter and his
2 1		passenger, he was struck on the posterior thigh
22		by the propeller of the rescue boat. His
23		passenger got into the rescue boat. He refused
24		rescue at the time because he wanted his boat
25		towed. And at a later time he was pulled out of

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1		the water by a jet skier and then brought to
2		Lorain Community Hospital.
3	Q	All right. Now, earlier you had mentioned you
4		believe the liver laceration occurred in the
5		operating room. And ${\tt I}$ am assuming that is
6		during the second debridement surgery and not .
7		the first?
8	А	During the attempts to resuscitate him following
9		the second debridement operation.
10	Q	That would have been approximately sometime
11		after 10:00 a.m., July 15th of that year?
12	А	Correct.
13	Q	Do you have any criticisms of any of the
14		personnel in the emergency room where <b>Mr.</b> Porter
15		first presented?
16	А	No.
17	Q	Do you have any criticisms of any of the medical
18		professionals who were involved in Mr. Porter's
19		first debridement surgery?
20	A	No.
2 1	Q	Do you have an opinion well, strike that.
22		Are <b>you</b> critical of Mr. Porter in any way,
23		either not being an accurate historian, failing
24		to adequately describe his symptoms or anything
25		along those lines?

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1	Α	No.
2	Q	Do you have any criticisms <b>of</b> the nurses who
3		were caring for Mr. Porter in the hospital, in
4		terms of their providing information to Mr.
5		Ghanma and the other physicians involved in his
6		care?
7	А	No.
8	Q	You have read and seen the photographs from the
9		coroner's report?
10	А	Yes.
11	Q	Do you disagree with any of the conclusions that
12		the coroners came to in that report?
13	А	Yes.
14	Q	Okay. Can you tell me what disagreements you
15		have?
16		MR. TRAVIS: I object.
17		Because he doesn't have the report before him.
18		But to the best of your ability, you can testify
19		from your memory, Doctor.
20	Q	And before you answer, I have absolutely no
21		problem with you getting the report in front of
22		you, if you want to review it. It is not a test
23		of memory. It has certainly been a number of
24		years.
25	A	Off the record.

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[Discussion had off the record.]

Back on the record. Mr. Madden asked me if I 2 Α 3 disagreed with the findings of the coroner's report dated 10 August, 1995. And I said I did. The coroner, Dr. Paul Matus, determined the 5 cause of death, a blunt impact to the abdomen 6 with laceration of liver and hemoperitoneum. 7 And I disagree with that. 8

0 Okay. Now, I am going to eventually ask you 9 about your opinions on cause of death. But I 10 just wanted to identify the areas of the 11 coroner's report with which you disagree. 12 Are 13 there any other conclusions that he has come to 14 or findings that he has made with which you disagree? 15

I disagree with the toxicology report. It said 16 Α that the drug screen only showed Lidocaine and 17 metabolites. Methylprednisolone. I don't 18 believe there are any other findings in the 19 20 final report.

Q Okay. Why don't we go ahead and touch on the 21 22 toxicology matter that you have disagreement 23 with. Tell me why you disagree with those findings? 24

25 Α Well, in reviewing the records, it is my

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27 impression this patient was given narcotics 1 2 while in the hospital during the previous 24 hours prior to this report. And I am at a loss 3 to understand why a drug screen wouldn't have 4 shown Demerol, Valium, Codeine that the patient 5 we know was given, based on the hospital 6 7 records. Q Is there any significance then, in your mind, on 8 that point, in other words, what conclusion do 9 10 you come to that the toxicology screen doesn't 11 show that? 12 That the toxicology screen is not accurate. Α Okay. All right. Now, Dr. Ghanma's first 13 Q 14 contact with this patient was in the emergency room on July 13th? 15 As best I can remember, I believe that is true. 16 Α 17 Okay. What, to your recollection, did Dr. Q Ghanma do with respect to that patient when he 18 first saw him? 19 I believe, from my memory, he took a history and 20 Α physical and performed a physical exam. 21 Let's go ahead and make an outline. We know 22 Q 23 that Dr. Ghanma saw the patient in the emergency 24 room on the evening of July 13th. We know that 25 a second contact would have been the first

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Ω⊳≽riΩ⊳ment proc⊳ <b>0</b> ur⊳ at about 20 minut⊳∃ past	mi@night on t⊅¤ mo≭ning of July 14t≻ H¤ ≻a∃	tpstifip <b>0</b> that hp sau t>p patipnt a>out 7.40 in	th⊵ morning on July 14th We know t≻at >> ∃aw	him arowny top Dinner Dour on toe same pate	And then we know that he saw the patient for the	s⊵conù û⊵≻≂iû⊵ment proc⊵ <b>u</b> ure on t≽e morning of	the 15th.	Hav⊵ I l¤ft an∯thing out, as far as you	гршепрег?	# I pelieve that is correct	Q I am ju∍t going to go through th⊮m at ⊮adh point	an0 Discuss pr. Ghanma's inwolw⊵ment anD <b>w&gt;</b> at	your imprø∃sions wer¤ o≷ it     Mh¤ chart Wo¤s not	røfløct whøn wr. Ghanma zaw tÞø patiønt in tÞø	ршрждрлсу гооп, that tbp Досtor рхапілрД tbp	аРДопре До уоц жрпрпург tbat?	# mbwrw is notbing in the cbart tbat reflects	that, correct	ן And you ≏nd I can ag≭שש that onש of the r⊮asons	why w¤ chart in a <b>p</b> ati¤nt∎s r¤corΩ a∃ to what	the Doctor Dops is to make a record of tbeir	activity and treatment trup?	A Correct.	Q And if something µo⊵∋n•t app⊵ar in th⊵ c≻art, it
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1		can be a fair inference that perhaps something
2		wasn't done, is that fair?
3		MR. TRAVIS: Objection. You
4		can answer, if you can.
5	A	I don't know how to answer that. I believe that
6		for accuracy, as you do, Mr. Madden, that <b>if</b> you
7		perform an exam the best way to document that
8		you performed it is to document it in the chart.
9	Q	Are you aware of any indications of the patient
10		having been either injured by lacerations or
11		contusions when he presented at the emergency
12		room, injuries that he suffered while in the
13		lake?
14	A	Yes. He had a severe laceration to his
15		posterior thigh, measuring approximately 12
16		inches in length. He had a laceration, I
17		believe, on his thumb. He had, I believe, a
18		nondisplaced fracture of the fibula.
19	Q	To your memory, were there any signs of bruising
20		or injury <b>to</b> the abdominal area in the right
21		lower quadrant?
22	А	None I don't recall any significant external
23		signs of injury to the abdomen.
24	Q	Is it a fair statement that with blunt abdominal
25		injuries you may sometimes have injuries to the

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1		internal organs with no exterior indication,
2		bruising or something <b>of</b> that nature?
3	A	That is certainly possible.
4	Q	Dr. Ghanma's first contact with the patient in
5		the emergency room, was there anything that you
6		felt was not done appropriately or adequately in
7		that visit?
8	A	I have no criticisms <b>of</b> that visit.
9	Q	If Mr. Porter had been brought to this hospital,
10		would an orthopedic surgeon have been called to
11		serve as his attending physician?
12	A	I believe so.
13	Q	Why is that?
14	Α	Because this patient had essentially a unisystem
15		injury to his extremity, his laceration. And at
16		this hospital lacerations to the extremities are
17		handled by orthopedic surgery.
18	Q	Could they also be handled by a trauma surgeon?
19	А	At another hospital?
20	Q	At this hospital?
2 1	A	That's possible.
22	Q	Could a plastic surgeon handle the debridement
23		procedures that were performed on Mr. Porter?
24	А	I believe so.
25	Q	Okay. Was there any reason why it was more

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1		beneficial to Mr. Porter to <b>have</b> an orthopedic
2		surgeon perform those surgeries as opposed to a
3		different specialist?
4	А	If he were at this hospital?
5	Q	Yes.
6	Α	Yes. I believe that orthopedic surgeons are
7		probably the most familiar with the anatomy and
8		the care of traumatic injuries to the
9		musculoskeletal system, particularly in the
10		extremities.
11	Q	To your knowledge, was a trauma surgeon consult
12		ever entertained when Mr. Porter was seen in the
13		emergency room?
14	А	At Lorain Hospital?
15	Q	Yes.
16	А	No.
17	Q	Okay. Should a trauma surgeon have been brought
3.8		in?
19	А	I don't believe <b>so.</b>
20	Q	Why is that?
2 1	А	Because I believe this was not ${f a}$ multiple trauma
22		situation. And I believe it was a unisystem
23		injury, meaning the primary injury was to the
24		left lower extremity, or I can't remember which
25		lower extremity, to the lower extremity. And
	1	

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1		there were not this was not a multi-trauma
2		situation.
3	Q	Okay. Now, I am not being smart with you, but
4		one of the reasons that you feel this was not ${f a}$
5		multi-trauma situation is because you believe
6		the liver laceration occurred <b>in</b> the operating
7		room on July 15th?
8	А	Correct.
9	Q	Okay. Now, I want you to assume that Dr. Ghanma
10		believed that there was an abdominal injury that
11		occurred while Mr. Porter was in Lake Erie. If
12		he had that knowledge in the emergency room on
13		July 13th, should he have made a trauma surgeon
14		consult?
15		MR. TRAVIS: Objection to the
16		hypothetical. You can answer, if you can.
17	A	Yes.
18	Q	And if he failed to do that, would you be $\cdot$
19		critical <b>of</b> his decision not to make such a
20		consult?
2 1	A	Yes.
22	Q	Would that have been a violation of the standard
23		of care, in your opinion?
24		MR. TRAVIS: Objection. That
25		is not a question.

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		3 3
1	Α	What is the question?
2	Q	If he had failed, <b>if</b> he had that knowledge and
3		failed to have a trauma surgeon consult, would
4		that be a violation of the standard of care, in
5		your opinion?
6		MR. TRAVIS: I am going to
7		object, unless you explain the nature $\boldsymbol{of}$ the
а		abdominal injury and be more specific in your
9		hypothetical.
10	Q	You can answer, if you understand it.
11	А	As I understand it, if the patient had a liver
12		laceration, and if he had signs of
13		intraabdominal trauma, would I and no general
14		surgical or a surgeon with abdominal expertise
15		was not called, would I be critical, do I feel
16		it would fall below the standard of care? Yes.
17	Q	To your knowledge, was a CT scan ordered in the
18		emergency room?
19	A	No.
20	Q	Should there have been one ordered?
2 1	А	No.
22	Q	And again, that is based on your belief that the
23		laceration <b>of</b> the liver occurred in the
24		operating room?
25	А	Yes. And the fact that his abdominal exam was

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1		benign in the emergency room.
2	Q	What was the abdominal exam and what did it show
3		in the emergency room?
4	А	I believe it was normal.
5	Q	What did Dr. Ghanma do? It is my understanding
6		he listened with the stethoscope and he palpated
7		the area. That is what he testified to.
8	A	And that is certainly sufficient. In addition
9		to the fact that he was examined by the
10		emergency room doctor and was examined by the
11		primary care physician, who did the history and
12		physical. All finding the abdomen to be within
13		normal limits.
14	Q	The next time Dr. Ghanma saw the patient was
15		approximately well, it was in the first
16		debridement procedure. Can you tell me or
17		summarize for me what you believe took place at
18		that time?
19	A	Yes. They brought the patient <b>to</b> the operating
20		room, placed the patient in the prone position
21		and did a debridement of the posterior thigh
22		wound.
23	Q	The patient went through the procedure just
24		fine, as I recall?
25	A	I agree.

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1		MR. MADDEN: Off the record
2		one second.
3		[Discussion had off the record.]
4	Q	Doctor, ${f I}$ may have asked an unclear question, so
5		let me go back. Do you recall testimony in this
6		case from Dr. Ghanma, that Mr. Porter complained
7		to him of pain in the right lower chest on July
8		14th, the day following the incident?
9	A	Yes.
10	Q	Okay. Can you tell me what you recall about
11		that?
12	Α	The doctors said that asked the patient if he
13		was having any abdominal pain and any loss of
14		appetite. The patient apparently noted some
15		loss of appetite and complained of pain in the
16		right lower chest, not the right lower quadrant.
17	Q	Okay. And I <b>was</b> inaccurate in saying quadrant.
18		Now, this complaint of pain occurred before the
19		second operating room procedure, where the liver
20		laceration occurred, in your opinion, correct?
21	А	Yes.
22	Q	Okay. Is this complaint <b>of</b> pain in the right
23		lower chest significant to you in any way?
24	A	Only to the point that he verbalized it to the
25		physician and the physician then had the

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1		opportunity to examine the patient to determine
2		if it were a significant injury.
3	Q	Given this complaint from the patient, should
4		Dr. Ghanma have ordered a trauma surgery
5		consult?
6	А	No.
7	Q	And that is your opinion to a reasonable degree
8		of medical probability, correct?
9	А	Correct. The surgeon's responsibility was to
10		take a history and perform a physical and based
11		on those findings decide as to whether further
12		consultation or laboratory studies need to be
13		carried out.
14	Q	And along those lines, should Dr. Ghanma, in
15		your opinion, have ordered a <b>CT</b> scan, given this
16		complaint from the patient?
17	Α	No.
18	Q	And for the same reasons?
19	Α	Correct.
20	Q	Was there anything else that you can recall
21		about Dr. Ghanma's visit with the patient on the
22		morning <b>of</b> July 14th, that we haven't discussed?
23	А	No.
24	Q	His next visit with the patient then was on the
25		evening of July 14th, correct?

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1	A	Correct.
2	Q	Do you recall that the doctor had ordered a
3		second CBC sometime in the morning of July 14th
4		and had the results by that time?
5	A	Yes.
6	Q	Do you recall what the results of that CBC were?
7	А	I can't give you the exact number but it showed
8		a decreased hematocrit and hemoglobin.
9	Q	What is the significance of a decreased
10		hematocrit and hemoglobin, bleeding? Internal
11		bleeding?
12	A	No.
13	Q	Not necessarily internal?
14	A	Bleeding, internal or external.
15	Q	Do you have any memory whether the results of
16		the H&H were specific in any way? Were they
17		severe?
18	A	I believe they were consistent with the
19		laceration that the patient had sustained and
20		the blood loss that would be due to that
21		laceration.
22	Q	Do <b>you</b> have any opinions as to the amount <b>of</b>
23		blood that Mr. Porter lost by this point?
24		MR. TRAVIS: At the time of
25		the second CBC?

		39
1	Q	Well, let's say by the evening of July 14th,
2		what the blood <b>loss</b> would have been?
3	A	As I recall, his hematocrit had dropped from $45$
4		or so in the emergency room and I believe,
5		correct me if I am wrong, that on the evening of
6		the 14th the hematocrit was 38, 35, something
7		like that.
8	Q	We can always confirm that if you want.
9	А	45.1 to 38.2. So the hematocrit had dropped
10		approximately 7 points, which would be
11		consistent with a severe laceration such as
12		that.
13	Q	Do you recall what the situation was with Mr.
14		Porter's blood pressure, if there was a trend
15		from the time he presented to the emergency room
i6		through the evening of July 14th, was it up or
17		down, hypotensive?
18	A	I don't recall the exact numbers, but ${\tt I}$ believe
19		his blood pressure had a trend, from the time he
20		was admitted until practically his cardiac
21		arrest, that the trend was down.
22	Q	With the falling $H\&H$ and a falling blood
23		pressure over that course of time, in your
24		opinion should Dr. Ghanma have considered an
25		internal bleed?

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I certainly believe he should have considered 1 Α the whole patient. Maybe I take issue with the 2 way you asked the question. Any physician would 3 4 consider bleeding from any source. He has got to figure out why the patient has **a** hematocrit 5 that moves from 45 to-38. 6 Well, was it appropriate for Dr. Ghanma to 7 Q

presume that it all be attributed to the leg laceration?

10 A I believe so.

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11 With a patient's complaint of a pain in the Q 12 right lower chest, with a history that the patient had had a pretty rough episode in the 13 14 lake with bouncing or contact, what have you, 15 with the falling H&H and the falling blood 16 pressure, should an internal bleed have been 17 part of Dr. Ghanma's thinking by the evening of 18 July 14th?

19 A I believe it certainly would be part of his 20 thinking. To the extent that he asked the 21 patient if there were any complaints, he would 22 examine the patient and then draw conclusions 23 based on what he found.

Q Again, with those considerations in mind, was
the CT scan warranted by the evening of July

		41
1		14th?
2		MR. <b>TRAVIS:</b> Objection; asked
3		and answered. You can answer again.
4	A	Not if the abdominal exam was not consistent
5		with significant intraabdominal injury.
6	Q	Is there anything else that you can recall about
7		Dr. Ghanma's visit with the patient on the
8		evening of July 14th that is significant to your
9		opinions in any way?
10	А	Nothing.
11	Q	This brings us then to the second debridement
12		procedure on July 15th. Was that surgery
13		necessary at that time?
14	А	Yes.
15	Q	Why is that?
16	Α	I believe the patient had a significant injury
17		that was had extremely high risk for
18		infection. And I believe the patient was
19		showing signs of sepsis.
20	Q	Tell me, first of all, what is your belief as to
2 1		why the patient was showing signs of sepsis by
22		that point?
23	А	An elevated temperature, he had a falling blood
24		pressure, and he had a highly contaminated wound
25		in his thigh.

		42
1	Q	Was <b>a</b> third CBC indicated, given falling H&H and
2		his conversation with the patient on the evening
3		of July 14th?
4	A	Third CBC at what point?
5	Q	By the morning of July 15th. In other words,
6		prior to the second debridement surgery?
7	A	I don't believe it was indicated unless the
а		surgeon or any other physician felt the need ${\mathfrak S}$ or
9		it. Personally, I don't think it was indicated.
10	Q	If a third CBC had been performed early in the
11		morning of July 15th, with the other conditions
12		as we know them, what do you believe that CBC
13		would have shown?
14		MR. TRAVIS: Objection. Are
15		you saying conditions as we know them in
16		retrospect at that time? Can you be more
17		specific.
18	Q	If you understand, fine, if not, I will rephrase
19		it.
20	А	I believe that a third CBC would have shown the
21		hematocrit to be slightly lower.
22	Q	All right. How much lower, can you quantify?
23	A	Well, the patient still had an open wound. We
24		know <b>he</b> was oozing. The wound was not closed.
25		It would have been too early for him to start

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1		making his own red blood cells to replace blood
2		that was lost. I believe it probably would have
3		been slightly lower.
4	Q	If the <b>H&amp;H</b> had come back slightly lower, if it
5		had fallen again in a third CBC, would it have
6		been appropriate to continue to proceed with the
7		second debridement surgery?
8	А	Absolutely.
9	Q	Tell me what your understanding is of the events
15		leading up to the second debridement surgery, as
11		far as Dr. Ghanma's involvement and who
12		interviewed the patient and <b>so</b> forth?
13	А	I don't understand the question.
14	Q	All right. Sorry.
15		Dr. Ghanma is going to perform the second
16		surgery. And Dr. Quansah is the
17		anesthesiologist, correct?
18	A	Correct.
19	Q	Do you recall whether Dr. Quansah or Dr. Ghanma
25		spoke with the patient immediately prior to the
2 1		second surgery?
22	A	I don't recall from memory. But I would assume
23		that the anesthesiologist probably spoke with
24		the patient prior to the second surgery.
25	Q	Do you recall if Dr. Ghanma spoke to the patient

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-1		immediately prior to the second surgery?
2	А	I don't recall.
m	Q	Do you have an understanding as to what Mr.
4		Porter's blood pressure was immediately prior to
ហ		the second surgery?
9	А	Yes. From the medical records.
7	Q	Okay. What would that have been, approximately?
ω	A	I don't recall the exact numbers, but I believe
σ		it was 90 over 60, perhaps.
10	Ø	And you have read Dr. Ghanma's second deposition
H H		where there was testimony about a blood pressure
12		reading of 67 over 46 before surgery had begun,
13		do you recall that?
ц 4		MR. TRAVIS: Again, can we
ы Ц		refer to a specific part of the deposition, if
9 H		you are going to make reference to it.
17		MR. MADDEN: Okay, let's go
1 8 1		off the record.
1 ð		[Discussion had off the record.]
20	A	We are back on the record.
21		I am looking at Dr. Ghanma's deposition of
22		September 2nd. And I was asked a question by
5 3		Mr. Madden as to what the patient's blood
24		pressure was on the morning of the 15th. I
25		incorrectly stated that I remembered it to be 90
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1		over 60 and it was actually <b>110</b> over 60.
2	Q	Okay.
3		MR. TRAVIS: Okay. And
4		also
5	А	Then I was asked by Mr. Madden if Dr. Ghanma had
6		spoken with the patient on the morning of
7		surgery. And in his deposition, page 8, line 9,
8		he stated that he spoke with the patient. And
9		the final question was whether Dr. Ghanma was
10		aware at approximately 9:12 a.m. what the
11		patient's blood pressure reading was and he
12		wasn't and the reading was <b>67</b> over 46.
13	ç	So we have clarified that. Thank you.
14		Before proceeding further with the second
15		debridement surgery, as a general proposition,
16		when a patient is proceeding to surgery and he
17		will be under general anesthesia, whose
18		responsibility is it to ascertain whether the
19		patient is suitable for general anesthesia?
20	A	The anesthesiologist.
21	Q	And how does the anesthesiologist go about
22		determining that?
23	A	Based on their review of the records, their
24		history with the patient and any physical
25		examination they perform.

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1	Q	And included in a physical examination would be
2		a blood pressure reading?
3	A	Yes.
4	Q	Would the anesthesiologist also review any CBC
5		results of any kind?
6	А	In my experience, they <b>do.</b>
7	Q	If the anesthesiologist was aware of the
8		patient's <b>blood</b> pressure at 67 over 46 prior to
9		commencing surgery, should that patient have
10		gone to surgery?
11		MR. TRAVIS: Objection. Are
12		you asking him to render an anesthesiology
13		opinion here?
14		MR. MADDEN: I am asking as a
15		general proposition here.
16		MR. FOGARTY: I am sorry, what
17		was that?
18	Q	Let's go back to it.
19		Given Mr. Porter's blood pressure at 67
20		over 46, was he suitable for general anesthesia?
21		MR. FOGARTY: At what time? I
22		am sorry, Justin.
23		MR. MADDEN: At 9:12 am.
24		MR. TRAVIS: Objection.
25		MR. FOGARTY: Is that after

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47 1 the anesthesia was started? MS. CUTHBERTSON: 2 During induction? 3 MR. MADDEN: 4 During induction. 5 6 MR. TRAVIS: Objection. You 7 can answer if you can, Doctor. I am not board certified in anesthesia so I have Α 8 no way of answering that question. 9 Okay. Should Dr. Ghanma have been made aware of 10 0 the patient's blood pressure at that time? 11 12 MR. FOGARTY: I am sorry, 13 Justin, are you talking about 9:12? 14 MR. MADDEN: 9:12. 15 MR. FOGARTY: 67 over 46. And you read from Dr. Ghanma's deposition where he 16 indicated that? 17 18 MR. TRAVIS: Right. MR. FOGARTY: 19 Okay. 20 MR. TRAVIS: He is not aware of that. Go ahead. 21 Α 22 Right, Dr. Ghanma was not aware of that. That is right. It is a complex question to answer. 23 24 And I am not trying to avoid it but there are 25 many reasons that a patient's **blood** pressure may

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1		be significantly low at induction. As to
2		whether to notify the surgeon or not would
3		depend on what the anesthesiologist feels is
4		causing that problem.
5	Q	When you say induction, ${f I}$ want to make sure. ${f I}$
6		have an idea what it means, but ${\tt I}$ am not sure
7		what it means. So can you tell me what
8		induction is?
9	A	Speaking as an orthopedic surgeon?
10	Q	Sure, again.
11	A	My, when ${\tt I}$ say induction it means the start of
12		anesthesia.
13	Q	When the mask is over the patient's face?
14	A	Starting to give the patient medications of any
15		sort, including medications intravenously or
16		through the lungs or injectable of any sort.
17	Q	When a patient is placed under general
18		anesthesia, whose responsibility is it to
19		monitor the patient's vital signs or hemodynamic
20		stability?
21	А	Anesthesia.
22	Q	Who has the responsibility to report or monitor
23		the patient's vital signs or to report that to
24		the surgeon?
25	А	The anesthesiologist.

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1	Q	<b>Do</b> you have an opinion whether the
2		anesthesiologist, in this second debridement
3		surgery, properly informed Dr. Ghanma <b>as</b> to the
4		patient's vital signs?
5		MR. FOGARTY: Objection.
6		MR. TRAVIS: Objection. You
7		can answer.
8	Α	Again, ${f I}$ am not an anesthesiologist. I can't
9		answer it based on that. Because there are many
10		reasons that vital signs will change. And it is
11		necessary to notify the surgeon if the vital
12		signs are changing for some unknown reason and
13		which the surgeon needs to be aware.
14	Q	Okay. What is your understanding as to what
15		occurred in the second debridement procedure,
16		given everything you have reviewed in this case?
17	Α	The patient was placed in the prone position.
18		During the procedure Dr. Ghanma was notified
19		that the patient's blood pressure was low and
20		Dr. Ghanma asked if he should stop and he was
21		told he should finish up. He finished up. And
22		as the patient was turned from the prone
23		position to the supine position, the patient had
24		a cardiac arrest.
25	Q	Whose call is it whether the surgery continues

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1		at the point where the question was asked,
2		should we stop, whose call is it to continue, to
3		go forward?
4	А	The anesthesiologist.
5	Q	Was there any particular reason why Dr.
6		Ghanma was there something else that Dr.
7		Ghanma had to finish which required him to $oldsymbol{go}$
8		forward when the anesthesiologist reported a
9		small problem?
10	A	I don't know that I have material to answer
11		that, other than to say Dr. Ghanma was aware of
12		it and stated he finished up as soon as he
13		could.
14	Q	Okay. I am going to represent to you that Dr.
15		Ghanma testified that, when the question was
16		raised whether to continue, it was his testimony
17		that there wasn't really anything else he really
18		needed to do, so the option was just that, an
19		option. Are you aware of that portion of the
20		testimony?
21		MR. TRAVIS: <b>I</b> am going to
22		object again. Let's show him the portion of the
23		testimony you are referring to.
24		MR. MADDEN: Okay, off the
25		record.

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1		[Discussion had $of \in$ the record.]
2	Q	Going back on the record now. I had earlier
3		represented to you, Dr. Ghanma's testimony in
4		his first deposition, that when the question
5		came up whether to stop the procedure Dr. Ghanma
6		testified that he could have stopped at that
7		point if the anesthesiologist had asked him to.
8		Did I summarize that correctly?
9	A	Yes.
10	Q	Okay. But the decision was made by the
11		anesthesiologist to continue the surgery.
12		MR. TRAVIS: Objection.
13		MR. FOGARTY: Objection.
14	Q	True?
15		MR. FOGARTY: That is not
16		really an accurate summary of what you just
17		quoted to the doctor before, about what the
18		anesthesiologist said, but go ahead.
19	Q	You testified earlier whose decision it <b>is</b>
20		whether to stop the surgical procedure?
21	A	Correct.
22	Q	Whose call is it?
23	A	The anesthesiologist.
24	Q	Okay. In this particular debridement surgery,
25		when the question was raised, was there anything

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1		else that Dr. Ghanma needed to do at the point
2		where the question came up?
3	A	He testified in his deposition that he could
4		have finished at that stage but he was told he
5		didn't have to finish at that stage.
6	Q	Do you have any criticisms of continuing that
7		procedure at that point?
8		MR, FOGARTY: Objection. That
9		is the third time you have asked him.
10	A	Again I can't answer that, not being an
11		anesthesiologist.
12	Q	Was Dr. Ghanma given all of the necessary
13		information at that point, in your opinion?
14	A	At that point the information Dr. Ghanma was
15		given is that he didn't have to finish at that
16		point, so he would take that to mean just what
17		it says.
18	Q	Okay. With everything you have had to review at
19		this point now, was that an accurate report to
20		Dr. Ghanma?
21		MR. FOGARTY: Objection.
22		MR. TRAVIS: Objection.
23	A	Again, you <b>would</b> have to ask an
24		anesthesiologist.
25	Q	Why don't you just tell me, in your own words,

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1		why did this patient die?
2	А	I believe this patient died <b>of a</b> combination of
3		sepsis and pulmonary embolism.
4	Q	Can you explain that?
5	А	Yes. I believe he I believe based on the
6		facts, that he was septic. I draw that
7		conclusion based on the fact that he had a
8		severe injury to his thigh. That we now had
9		necrosis of muscle was infected with bacteria,
10		including gram negative bacteria, that his blood
11		culture postmortem showed gram negative bacteria
12		and gram positive bacteria in the blood.
13		Clearly that defines sepsis. I believe that at
14		the cardiac arrest, he had signs of right heart
15		obstruction and that, together with the fact
16		that he was a young, healthy patient, with a
17		severe injury to his extremity, means pulmonary
18		embolism to me.
19	Q	Let's talk about the pulmonary embolism for a
20		minute. Was there ever a finding by the coroner
21		of any indication of a pulmonary embolism?
22	Α	No.
23	Q	Do you then disagree with something that the
24		coroner did in this case, is it your belief the
25		coroner missed it? What happened to it?

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It is my belief that the coroner missed it. 1 Α 2 Why would it have gone, how would he miss it? Q I believe that the patient had a large blood 3 Α clot that was obstructing the right heart. 4 That he was given a chemical agent to dissolve blood 5 clots, called **TPA.** That he underwent an 6 7 extended period of CPR, various experts have calculated something up to 1500 or more 8 compressions of his chest. And that the clot 9 was pushed further into the pulmonary trunk, 10 meaning vasculature, and that the three slides 11 that were taken at the time of the coroner's 12 autopsy were probably not sufficient to find the 13 blood clot. 14 Before I forget, do you have any criticisms of 15 Q the resuscitation efforts by the code team in 16 this matter? 17 18 Α No. In the process of administering CPR, is it your 19 0 opinion that that is where the liver laceration 20 occurred? 21 22 Α Yes. How is that explained? 23 Q 24 Α When performing CPR, in order to utilize the heart as a pump mechanism, you must compress the 25

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1		this point he is in the hospital maybe <b>48</b> hours
2		at the most. And your belief is that he had
3		sepsis by that point?
4	A	Yes.
5	Q	Okay. How is that explained?
6	A	I find it easily explainable by the factathat <b>we</b>
7		know as a fact that the patient's blood culture
8		at the time he died grew bacteria, grew
9		gram-negative bacteria and gram-positive cocci,
10		both very significant pus-producing organisms.
If		They were in his blood at the time he died. He
12		also had an infection in his wound, positive
13		cultures, including those gram-negative
14		bacteria. Therefore, sometime from the time the
15		injury occurred and what we know were polluted
16		waters, near a sewage treatment plant, the
17		bacteria which entered his body through this
18 🗉		severe laceration, then entered his bloodstream.
19		And as soon as they entered his bloodstream, by
20		definition he is septic.
2 1	Q	Okay. Septic enough to cause his death
22		independently or in combination with pulmonary
23		embolism?
24	Α	I don't know how I can answer that question.
25		Certainly I believe he died from combination of

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presentation in the emergency room, the injuries		2 5
Given what you know about Mr. Porter's	Ю	24
No.	A	23
he was in Lake Erie?		22
just inconsistent with him being injured while		21
laceration occurred that you would say it is		20
Okay. Is there anything about where this liver	Ø	19
occur with blunt abdominal trauma.		18
As a general matter, injuries to the liver can	3.1	17
or injuries to the liver?		16
find, as a general matter, are liver lacerations		ц П
abdominal injury, one of the main things you		14
The literature indicates in the cases of blunt	Ø	13
answer if you can, Doctor.		12
Unless you can explain what you mean. You can		1 1
MR. TRAVIS: Objection.		10
blunt abdominal injuries?		9
with relatively high percentage when you have		ω
Would you agree that liver lacerations occur	Ø	7
Yes.	A	σ
laceration can occur in the process of CPR?		ហ
Now, you wan also indicated twat liver		4
Certain⊥y a pulmonary embolism coul <b>d d</b> o t≌at?	Ø	ω
two.		N
the two• but you can die from either on≏ of the		н
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1	Q	Is the same true with the 15th?
2	А	On the 15th, I believe he was becoming unstable,
3		with a dropping blood pressure.
4	Q	Do you have an opinion as to why that blood
5		pressure continued to fall through the 15th?
6	A	Yes.
7	Q	And what is that?
8	А	I believe he was septic.
9	Q	If a patient is septic, what sort of symptoms
10		will they exhibit?
11	A	There is a myriad <b>of</b> symptoms. Some patients
12		there is almost no symptoms and some patients
13		can be extremely ill, meaning mentally agitated
14		or marked changes in mental status, delirious,
15		even to asymptomatic, mentally. They can have a
16		high pulse, high temperature or they can have a
17		low temperature. Sepsis, by definition, is
18		pathogens that are pus producing or toxic
19		producing in the bloodstream and it would
20		depend, to a large extent, what type of
2 1		pathogens are involved and what the patient's
22		immune system is like.
23	Q	During the second debridement you may recall
24		that there was testimony that the endotracheal
25		tube came out of the patient's mouth, at or

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1		about the time that the patient was rolled on to
2		his back. Do you recall that?
3	A	Yes.
4		MR. <b>TRAVIS:</b> Object. The
5		tube was found out of the mouth at that time. ${ t I}$
6		don't know whether you can say anything beyond
7		that. But with that objection, please continue.
8	Q	We can agree at some point while the patient was
9		under, the endotracheal was out of the mouth,
10		correct?
11	А	Yes.
12	Q	What is your understanding as to why that
13		happened or do you have any understanding <b>as</b> to
14		what occurred?
15	А	<b>Only</b> to the extent that the endotracheal tube
16		was found out of his mouth when they turned him.
17		I don't have an understanding as to how that
18		occurred.
19	Q	Do you have an opinion as to how long the tube
20		was out of his mouth?
21	A	No.
22	Q	Do you have an opinion as to whether the tube
23		being out of the patient's mouth in any way
24		contributed to his death?
25	Α	No.

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1	Q	Did it compromise his condition at all?	
2	Α	I don't know. It would depend on how long it	
3		was out of his mouth and whether he was being	
4		ventilated or whether he was ventilating himsel	f
5		during that time.	
6	Q	${\tt I}$ am going to assume, and pardon the stupid	
7		question, ${\tt I}$ am going to assume that a tube	
8		coming out a patient's mouth during surgery is	
9		an unusual incident?	
10	А	I believe it came out after his surgery, when	
11		they were turning him. But again, <b>as</b> Mr. Travis	S
12		pointed out, we don't know. We know that it was	5
13		found out of his mouth. <b>So</b> it occurred sometime	е
14		during that period.	
15		MR. <b>TRAVIS:</b> Your expert has	
16		not made an issue of it, I presume.	
17	Q	I am just trying to figure out what your	
i8		understanding is of that part <b>of</b> the surgery.	
19		Let me ask you another question.	
20		Was the code in this case called timely,	
21		in your opinion?	
22	A	I don't know. I don't know enough about	
23		anesthesia to know what was going on during the	
24		orthopedic procedure, as to what the	
25		ventilation, cardiac problems are. I don't know	N

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the answer.

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Q In your report, your last opinion, your last 2 3 paragraph on the first page, is fairly straightforward. And if I can describe it, you 4 5 have qualified that opinion to say from an orthopedic standpoint. And I take it that is 6 because that is the only speciality from which 7 you are speaking on this case? 8 That's correct. 9 Α Are there any other opinions that you hold in 10 0 this case, that you and I have not discussed? 11 12 MR. TRAVIS: Objection. Ιf 13 you ask him a question he will probably have an answer but --14 Whether Mr. Travis likes it or not but -- not 15 Α that I know of. 16 17 0 We have talked about whether you hold criticisms on various portions. Have we discussed any and 18 all criticisms that you hold in this case? 19 In other words, this is my chance to find out what 20 you are going to say at trial. If there is 21 22 something else that you are going to testify to 23 in this case, this is the time for me to find out about it. 24 I agree. And I know that is your job, which you 25 Α

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1		are doing a nice job at.
2		None that I can recall, Mr. Madden. We
3		covered most of the criticisms that I can
4		recall.
5		MR. MADDEN: Okay. Why don't
6		you give me one minute, just to run through some
7		things.
8		MR. FOGARTY: Justin, do you
9		want me to ask some questions?
10		MR. MADDEN: I was going to
11		ask if anybody else has anything. Go ahead,
12		touch on things.
13		EXAMINATION OF RANDALL MARCUS, M.D.
14	BY MR.	FOGARTY:
15	Q	Dr. Marcus, my name is Dennis Fogarty, I
16		represent Dr. Quansah. Just a couple of
17		questions.
18		The second debridement, as was the first
19		debridement, both involved a procedure called
20		pulse lavage. Do you know what that is? Can
21		you explain that procedure, please?
22	A	Yes. That is a technique that most of us are
23		using for open wounds, including open fractures.
24		It is akin to a water pick that people use in
25		their mouth. And what we do is under pressure,
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1		we water pick, if you will, <b>or</b> pulse lavage with
2		water, with saline or any fluid. Lots of times
3		we'll use an antibiotic fluid to mechanically
4		wash out the wound.
5	Q	Okay. All right. And does it require you to
6		actually I mean are you washing the wound
7		internally, in other words, are you breaking the
8		tissue, or is it all just external, around and
9		in the wound itself? <b>Do</b> you understand the
10		question?
11	A	I am not sure I do.
12	Q	Is it possible to break tissue with the lavage?
13	А	Break tissue?
14	Q	Just tear the tissue or lacerate the tissue at
15		all with this lavage?
16	Α	Not significantly, no.
3.7	Q	Okay. All right. The fact that the post mortem
18		blood cultures grew to gram-negative bacteria
19		and also you said the wound itself, the tissue
20		showed necrosis, indicates that we had, at least
2 1		at the time of the second debridement, ${f a}$ rather
22		advanced infected wound, correct? The infection
23		had advanced substantially, correct?
24		MR. MADDEN: Objection.
25	Α	I think you are perhaps asking two different

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1		things. The fact that the patient had both gram
2		negatives and gram positives in his bloodstream
3		means he was septic.
4	Q	Okay.
5	A	The sepsis, I believe, occurred from the wound.
6	Q	Right. Okay.
7	A	And you asked if that meant his wound was
8		infected?
9	Q	Yes. What does the necrosis, necrotic muscle,
10		say to you?
11	A	That there is dead muscle in the wound.
12	Q	Caused by?
13	A	Probably caused by loss of circulation to that
14		muscle.
15	Q	Okay. These postmortem findings, would that
16		support <b>or</b> indicate even more the necessity of
17		this second debridement procedure?
18	А	Yes.
19	Q	There is no question in your mind that this
20		procedure needed <b>to</b> be done, correct?
21	A	Absolutely.
22	Q	This <b>was</b> the source of the infection that led to
23		the sepsis?
24	A	Yes, as best I can tell.
25	Q	All right. And the best way to treat a sepsis

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10 9	is to control the Bource correct?	A You must dedride the wound Furthermore I	Daliawa tPat wowno nagaogo to Da Ogbrioga in tPa	opprating room	Q Okay All right An <b>p</b> the postmortem finding	further Dolsters your opinions regar <b>b</b> ing that,	correct?	A Correct.	Q Oxay. I noted that after gou rowipwop the	auto <b>p</b> #y finWings that gou <b>p</b> ointp <b>P</b> out corrpctlg	t at the toxicology failed to reweal the	prøgence of the narcotics tbat we know had bøen	pr¤∃c⊼i>»µ Muring Mr. Port¤r's ho∎pital stax	What if angthing <b>b</b> owm that twll gou	ж¤garΩing th⊵ accwracy l⊵t s say the mann⊵r in	which the autopey was performed? Does that cast	amything in dou>t in t⊮r⊟s of th¤ µroc¤µwr¤≡	us¤µ or th¤ r¤∎ults that cam¤ out of th¤	auto <b>p</b> ≢y, in you≂ mind?	A MR <b>h</b> DDEN: OÞjæction.	Α Ι ωill αποωρκ it the same way I answerpΩ is ωhem	Mr. Mappen asked me that question. It means	that the toxicology test was not accwrate.	Either from tee way it was performe <b>n</b> the wag it	wa∎ collpctpp Dut it was not accuratp	Capy & Manous R¤porting S¤rvic¤∃ Inc
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1	Q	Okay. All right. In your report you indicated
2		that the wound itself, and ${\tt I}$ assume the
3		infection that developed, made this injury a
4		limb-threatening injury, even on admission,
5		would you agree with that?
6	A	I testified that ${f I}$ felt it was ${f a}$
7		life-threatening injury.
8	Q	Okay. All right. I understand that. That is
9		what I was going to get to next. But the injury
10		itself, even without the sepsis finding, this
11		was a limb-threatening injury, would you agree?
12	A	Yes.
13	Q	With the development of the bacteria ${\tt I}$ am
14		sorry the infection, then you know it also
15		became a life-threatening injury, correct?
16	A	One would predict an injury such as this would
17		become infected and therefore it was limb and
18		life threatening for the same reason.
19	Q	Okay. Do you have an opinion whether Mr. Porter
20		would have arrested even with ut this second
2 1		debridement procedure?
22	А	I don't know.
23	Q	Clearly he was at risk for whatever risks he had
24		for pulmonary embolism that existed even prior
25		to this second debridement, would you agree with
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1		that?
2	A	Yes.
3	Q	Okay. And the risks associated with the sepsis
4		existed more so prior <b>to</b> this second debridement
5		procedure, correct?
6	A	Correct.
7	Q	Okay. So this patient was in trouble prior to
8		this second debridement procedure, correct?
9	A	Correct.
10		MR. FOGARTY: All right. That
11		<b>is</b> all I have, Doctor. Thanks.
12		EXAMINATION OF RANDALL MARCUS, M.D.
13	BY MS.	CUTHBERTSON:
14	Q	My name is Pattie Cuthbertson. I have already
15		introduced myself. And I represent St. Joe's
16		Lorain Hospital in this case.
17		Doctor, one document you weren't provided
18		with was the supplementary affidavit by the
19		plaintiff's expert, Dr. Shapiro. And in that
20		affidavit, which I am not going to show you, ${\tt I}$
2 1		am just going to represent to you that he claims
22		that the nurses failed to report information
23		about the patient's condition to Dr. Ghanma and
24		perhaps other physicians. With that bit of
25		information, do you, after your thorough review

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69 of this medical record, have any criticisms of 1 2 any of the health care providers at Lorain St. Joe's? And I am talking about employees of the 3 4 facilities. 5 MR. MADDEN: Patty, **I** will 6 just object. And I don't know why you don't 7 want to show him something, then you wanted to 8 ask him, with that information does he have an 9 opinion. But you can do what you want. 10 MS. CUTHBERTSON: Because maybe I 11 will get that thing struck and we won't need it 12 later on. 13 А I will agree with Mr. Madden. You are asking me 14 about something I haven't seen and I haven't 15 studied. So you are telling me --Well, then --16 Q What are you telling me? Are you telling me --17 Α 18 MS. CUTHBERTSON: Let's qo off the record a minute. 19 20 [Discussion had off the record.] 21 Q I will identify it €or him. 22 I have just showed you, Doctor, what is an 23 affidavit of Mark Shapiro, the plaintiff's 24 expert, that was attached to a pleading filed in 25 this case.

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70 1 Based on your review of that affidavit, 2 along with your review of the medical records in 3 this case, I just want to ask you to confirm 4 that you have no criticisms of any of the health 5 care providers employed by St. Joe Lorain 6 Hospital in this case? 7 Objection. MR. MADDEN: 8 Α I have no criticisms. 9 0 A couple of other questions. 10 Are you aware that the post mortem showed 11 that this patient had 1500 cc's of blood in his 12 abdomen? Are you aware of that? 13 Α Yes. 14 Is that a great deal of blood, given his Q Yes? 15 circumstances and his condition? 16 Α A great deal of blood? 1500 cc's represents 17 approximately 3 units of blood. Is that your question? 18 19 Is that a great deal of blood? Let me ask it to 0 20 you different -- you can't answer that question? 21 You can't answer the way it is phrased? 22 Α I can't answer to "a great deal." 23 Why don't you tell me what a great deal is? 0 24 Α I won't use the term, a great deal **of** blood. 25 0 Okay.

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1	A	Because if I use that, my colleagues would think
2		that $I$ didn't know what $I$ was talking about.
3		That is medically, that is nothing personal.
4		What are you asking?
5	Q	Should a patient of this age and this condition
6		be able or would you have expected him to
7		survive <b>a</b> blood loss of that degree?
8	A	Absolutely.
9		MS. CUTHBERTSON: That is <b>all</b> I
10		have.
11		MR. MADDEN: Off the record.
12		[Discussion had off the record.]
13		REEXAMINATION OF RANDALL MARCUS, M.D.
14	BY MR.	MADDEN:
15	Q	These questions raise some follow-up questions
16		that I need to ask.
17		Mr. Fogarty asked about whether the
18		patient was at risk for pulmonary embolism with
19		this injury. Can you tell me ${f a}$ little more
20		about your answer on that, was he at risk and,
21		if so, to what degree?
22	А	Yes. Any patient that is placed at decreased
23		activity level, that has an injury to the lower
24		extremity, is at increased risk over the general
25		population for pulmonary embolism.

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72	Q Dip the care <b>p</b> rowipers take steps. with regards	to Mr. Porter to safeguarD against a pulmonary	embolism?	A Not that I am aware of.	Q Should Dr. Ghanma have administered any sort of	agwnt, any kinw of mwwication, to safwguarw	against a pulmonary ⊭ <b>m0</b> ₀li∃m?	A HDwrw is no completely safeguarD against	puûmonary ¤m@olism Ah¤ p≂opl¤m with this	patient is we have a ploom loss proplem with a	large open wound that was contaminated app	therefore could not be closed And therefore, I	µon∎t ¥now of any ∍ignificant ag⊮nt that coulµ	haw» Уррп изр№ to <b>р</b> ⊭емриt pulmonary рщ©oli∃m at	this point in time.	Q Are there exercises or activities with a patient	that you wowld have the nurses or whopener was	caring ≷or the <b>p</b> ∃ti⊵nt a <b>Dmini</b> ∃t⊵r to t <b>&gt;</b> ⊵ <b>p</b> ati⊵nt	prior to the second debrivement?	MS CWHXBERTSON: ODjection.	A I know o≷ no ¤x¤∓ci∃¤∃, oth¤r than trying to	mobilize the patient, whice they weren t able to	No ⊅¤cawae o≷ t⊅¤ a¤w¤rity o≲ th¤ lac¤ration at	this point W>pn I say this point in time in	the last answer, in t <b>&gt;</b> is answer, meaning on t <b>&gt;</b> e	
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<ul> <li>13th, 14th or 15th of the hospital stay for this patient.</li> <li>Q You also told me and told Mr. Fogarty, it is your opinion that the toxicology report for Mr. Porter is not accurate, because it caught the presence of some things but not the presence of others. Did I summarize what your testimony was correctly?</li> <li>A I felt it wasn't accurate because we know he has had narcotics such as, I believe, Demerol, Valium, Codeine, and it did not pick up any of those.</li> <li>Q I assume you are not board certified in pathology, right, or toxicology?</li> <li>A That is true.</li> <li>Q And so is it a fair question to you, how you could perform a toxicology screen inaccurately?</li> <li>I am just wondering how that can happen.</li> <li>I don't know how it can happen. I believe this one was inaccurate.</li> <li>Q You also testified that you believed this patient was septic because of the presence of various bacterias that were found by the coroner; is that fairly summarized?</li> <li>A I believe he was septic, because my definition</li> </ul>			73
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1	THE STATE OF )
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4	Before me, a Notary Public in and for said state
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6	and county, personally appeared the above-named
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8	Randall E. Marcus, M.D., who acknowledged that he
9	
10	did sign the foregoing transcript and that the same is
11	
12	a true and correct transcript of the testimony $oldsymbol{so}$
13	
14	given.
15	IN TESTIMONY WHEREOF, ${f I}$ have hereunto affixed my
16	name and official seal at,
17	this day of, 1999.
18	Randall E. Marcus, M.D.
19	Randall E. Malcus, M.D.
20	Notary Public
21	My Commission expires:
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Cady & Wanous Reporting Services, Inc.

CERTIFICATE 1 THE STATE OF OHIO, ) SS: COUNTY OF CUYAHOGA. I, Robert J. Wanous, a Notary Public within and 2 for the State of Ohio, duly commissioned and qualified, 3 do hereby certify that the within-named witness, 4 Randall E. Marcus, M.D., was first duly sworn to 5 testify the truth, the whole truth and nothing but the 6 truth in the cause aforesaid; that the testimony then 7 given by him was by me reduced to stenotypy in the 8 presence of said witness, afterwards transcribed on a 9 computer/printer, and that the foregoing is a true and 10 11 correct transcript of the testimony so given by him, as 12 aforesaid. I do further certify that this deposition

I do further certify that this deposition
was taken at the time and place in the foregoing
caption specified.

PAOD 6.31 6989

I do further certify that I am not a 16 17 relative, counsel or attorney of either party, or otherwise interested in the event of this action: 18 IN WITNESS WHEREOF, I have hereunto set my hand 19 20 and affixed my seal of office at Cleveland, Ohio, on this direct day of July 1999). 21 ano 22 Robert  $\mathcal{J}_{\checkmark}$  Wanous, Notary Public 23 within and for the State of Ohio My Commission expires November 22, 2000. 24 25

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ERRATA SHEET

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# **CURRICULUM VITAE**

Name:	RANDALL EVAN MARCUS, M.D Professor of Orthopaedic Surgery		
Address:	Department of Orthopa Case Western Reserve University Hospitals of 11100 Euclid Avenue Cleveland, Ohio 44 106	University Scho Cleveland	ol of Medicine
Telephone:	( <b>216</b> )844-3041	<b>Fax:</b>	(216)844-5970

### PERSONAL DATA

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Date of Birth:	February 10, 1950
Marital Status:	Widower; (Anne Mulligan Marcus, d. 1997)
Children:	Blair Mulligan Marcus (b. 1992)

# **EDUCATION**

The Merairie Park Country Day School, New Orleans, Louisiana - Graduate 1968

Tulane University, New Orleans, Louisiana - B.S. (Magna Cum Laude) with honors in Biochemistry (Phi Beta Kappa) 1972

Louisiana State University School of Medicine. New Orleans, Louisiana - M.D. (Sigma Xi) 1975

Case Westem Reserve University School of Medicine, Cleveland, Ohio - Rotating Surgical internship 1975 - 1976

Case Western Reserve University School of Medicine, Cleveland, Ohio - Assistant Resident in General Surgery 1976-1977

Case Western Reserve University School of Medicine, Cleveland, Ohio - Resident in Orthopaedics 1977 - 1979

Case Western Reserve University School of Medicine, Cleveland, Ohio - Chief Resident in Orthopaedics 1979 - 1980

Oxford University, Oxford, England - Fellow, Nuffield Department of Orthopaedic Surgery 1980- 1981



University of Basle, Basle, Switzerland - A. O. International Fellow, Department of Surgery (Prof. - Dr. M. Allgöwer) 1981

University of Washington, Seattle, Washington - Senior Fellow, Department of Orthopaedics, Harborview Medical Center 1981

## ACADEMIC APPOINTMENTS

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Post-Doctoral Fellow in Surgery, Case Western Reserve University School of Medicine, 1975 - 1977

Post-Doctoral Fellow in Orthopaedics, Case Western Reserve University School of Medicine, 1977 - 1980

Fellow. Nuffield Department of Orthopaedics, Oxford University, 1980-1981

Senior Fellow, Department of Orthopaedics, University of Washington, 1981

Instructor in Orthopaedic Surgery, Case Western Reserve University School of Medicine, 1981 - 1982

Assistant Professor of Orthopaedic Surgery, Case Western Reserve University School of Medicine. 1982 - 1983

Assistant Clinical Professor of Orthopaedic Surgery, Tulane University School of Medicine, 1984 - 1985

Assistant Clinical Professor of Orthopaedic Surgery, Louisiana State University School of Medicine, 1984 - 1985

Assistant Professor of Orthopaedic Surgery, Case Western Reserve University School of Medicine, 1986-1991

Director, Division of Foot and Ankle Surgery, Department of Orthopaedics, Case Western Reserve University School of Medicine, 1987

Associate Professor of Orthopaedic Surgery, Case Western Reserve University School of Medicine, 1992-1997

Professor of Orthopaedic Surgery. Case Western Reserve University School of Medicine, 1998-present

#### **HOSPITAL APPOINTMENTS**

e · · ·

Attending Orthopaedic Surgeon, University Hospitals, Cleveland, Ohio, 1981 - present

Director, Division of Orthopaedic Trauma, University Hospitals, Cleveland, Ohio, 1981-1983

Consultant Orthopaedic Surgeon, Veterans Administration Hospital, Cleveland, Ohio, 1981 - present

Clinical Chief. Regional Prosthetic Amputee Clinic, Veterans Administration Hospital, 1989 - present

Director, Division of Foot and Ankle Surgery, University Hospitals, Cleveland, Ohio, 1987 - present

### **BOARD CERTIFICATION**

Diplomate, American Board of Orthopaedic Surgeons, 1982 Recertification, American Board of Orthopaedic Surgeons, 1996

### LICENSURE TO PRACTICE MEDICINE

Ohio - 1976 Louisiana - 1975

### MEMBERSHIP IN PROFESSIONAL SOCIETIES (BY ELECTION)

### **National and International**

Fellow, American College of Surgeons, 1984

Fellow. American Academy of Orthopaedic Surgeons, 1984

orthopaedic Trauma Association, 1986

Societé Internationale De Chirurgie Orthopaedique Et De Traumatologie (SICOT), 1991

American Orthopaedic Foot and Ankle Society, 1992

Association of Bone and Joint Surgeons, 1996

#### Local

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Cleveland Orthopaedic Society, 1981 (Board of Directors 1986-1989)

Innominatum Medical Society of Cleveland, 1986 (Board of Directors 1988 - 1993) (Secretary-Treasurer 1988 - 1990) (President 1990 - 1991)

Cleveland Aesculapian Medical Society, 1986 (Board of Directors 1991 - 1995) (President 1993 - 1994)

The Pasteur Club of Cleveland, 1991

### NATIONAL APPOINTMENTS AND COMMITTEES

American Board of Orthopaedic Surgeons, Written Examination Committee Question-Writing Task Force, 1983 - Present

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American Board of Orthopaedic Surgeons, Written Recertification Examination Question-Writing Task Force, 1991 - 1992

American Board of Orthopaedic Surgeons, Written Recertification Examination Standard Setting **Task** Force - 1996

American Board of Orthopaedic Surgeons, Recertification Examination Adult Reconstruction Question-Writing Task Force, 1996 - present

### **REGIONAL AND LOCAL APPOINTMENTS AND COMMITTEES**

American Red Cross of Northern Ohio - Medical Advisory Board, 1992 - present

Cleveland Health Museum - Board of Directors, 1992 - present

### CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE AND UNIVERSITY HOSPITALS OF CLEVELAND COMMITTEES

School of Medicine Comprehensive Exam Committee, 1986-1989

University Hospitals Autologous Blood Transfusion Committee (Chairman), 1992 - present

University Hospitals Preadmission Testing Committee, 1994 - present

University Hospitals University Faculty Practice Association Utilization Management Committee, 1995 - present

University Hospitals Observation Unit Committee, 1996 - present

University Hospitals Department of Orthopaedics Credentialing Committee, 1996 - present

### EDITORIAL BOARDS AND REVIEWER

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Member, Board of Editors, Today in Medicine, New York, N.Y., 1989-1995

Editorial Reviewer, The Journal of Bone and Joint Surgery

Editorial Reviewer, The New England Journal of Medicine

Editorial Reviewer, Clinical Orthopaedics and Related Research

### **UNITED STATES PATENT AWARDS**

U.S. Patent 4,622,959: Multi-Use Femoral Intramedullary Nail, November 18, 1986

#### **GRANTS AND FUNDED RESEARCH (Principal Investigator)**

1.	Metabolic Response of Mus Fixation and Early Mobilizati		etal Trauma: Effect of Internal
	Robert J. Frackelton Fund		1982-1984
а.	Metabolic Response to Traum Orthopaedic Research and Ec		
	Ormopaedie Research and Le	\$24,000.00	1983-1985
3.	Metabolic Response of Mus Fixation and Early Mobilizati Research Fund of 1942 - Uni	ion	tal Trauma: Effect of Internal
		\$18,000.00	1986
4.	Ceramic Endoprosthesis Imp Smith & Nephew Richards G	•	
		S60.000.00	1990-1993
5.	Hematocrit and Coagulation	Following Joint Replace \$2,500.00	ement 1992
б.	1	Alpha to the Standard of	Comparing the Pre-Operative of Care in Blood Conservation onstruction 1997-present

### **BIBLIOGRAPHY**

### **Published Papers**

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- 2. Marcus. R.E.; Albers, W.E.; and Thompson, G.H.: Extruded Osteochondral Nail: <u>Clinical</u> <u>Orthopaedics and Related Research</u>, Vol. 157, pp. 161-163, 1981.
- 3. Marcus, R.E.: The Orthopaedic Management of the Multiply Injured Child, In <u>Problematic</u> <u>Musculoskeletal Injuries in Children</u>, edited by G. R. Haughton and G. H. Thompson, pp. 193-210, London: Buttenvorths, 1983.
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- 7. Smith, A.D.; Carter, J.B.; and Marcus, R.E.: The Os Vesalianum: An Unusual Cause of Lateral Foot Pain, <u>Orthopaedics</u>, Vol. 7, pp. 86-89, 1984.
- Thompson. G.H.; Wilber, J.H.: and Marcus, R.E.: Internal Fixation of Fractures in Children and Adolescents: A Comparative Analysis. <u>Clinical Orthopaedics and Related Research</u>. Vol. 188.pp. 10-20, 1984.
- 9. Bargar, W.L.; Marcus, R.E.; and Ittleman, F.P.: Late Thoracic Outlet Syndrome Secondary to Pseudarthrosis of the Clavicle, <u>The Journal of Trauma</u>, Vol. 24, No. 9, pp. 857.859, 1984.
- Marcus, R.E.: and Hansen, S.T.: Bilateral Fracture-Dislocation of the Sacrum, <u>The Journal</u> of Bone and Joint Surgery, Vol. 66A. pp. 1292-1299, 1984.
- 11. Marcus, R.E.: Balourdas. G.M.; and Heiple, K.G.: Chevron Ankle Arthrodesis, Orthopaedics/Rheumatology Digest, August, pp. 27-29, 1984.
- 12. Marcus, R.E; Smith, A.D.; and Carter, J.B.: Treatment of the Os Vesalianum, <u>The Year</u> Book of <u>Podiatric Medicine and Surgery</u>, pp. 1620-1621, 1985.

- 13. Zdeblick, T.A.; Lederman, M.M.; Jacobs, M.R.; and Marcus, R.E.: Preoperative Use of Providone-Iodine: A Prospective, Randomized Study, <u>Clinical Orthopaedics</u> and <u>Related</u> <u>Research</u>, Vol. 213, pp. 211-215, 1986.
- 14. Klein, L.; and Marcus, R.E.: Multiple Trauma in Children: Management, Prognosis and Metabolism, <u>Trauma in Children</u>, edited by R.E. Marcus, pp. 1-12, Maryland: Aspen Publishers, 1986.
- 15. Marcus, R.E.; and Hansen, S.T.: Bilateral Fractures of the Tibia: A Severe Injury Associated with Multiple Trauma, <u>The Journal of Trauma</u>, Vol. 27, No. 4, **pp.** 415-419, 1987.
- 16. Marcus, R.E.; and Heiple, K.G.; Arthrodesis of the Ankle, <u>Operative Orthopaedics</u>, edited by M.W. Chapman, Philadelphia, J.B. Lippincott, 1988.
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- Goodnough, L.T.; and Marcus, R.E.: Homologous Blood Transfusion Needs in Elective Orthopaedic Surgery: Potential Role of Erythropoietin Therapy, <u>New England Journal of</u> <u>Medicine</u>, (at the request of the editor) Vol. 322, No. 6, pp. 1158-1159, 1990.
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- 22. Marcus, R.E.: The Ankle and Foot, <u>Orthopaedics: Problems in Primary Care</u>, edited by R.E. Marcus, pp. 185-208, Los Angeles, P.M.I.C., 1991.
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- Marcus. R.E.: The Effect of Erythropoietih on Red Blood Cell Volume in Autologous Blood Donors, <u>Continuing Education in Orthopaedic Surgery</u>, Orthopaedic Audio-Synopsis Foundation, Vol. 25, No. 7, October 1993.
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- 33. Goodnough. L.T.: and Marcus, R.E.: The Effect of EPO Therapy on Red Cell Volume Expansion in Autogenous Blood Donors Undergoing Elective Orthopaedic Surgery, <u>Contemporary Orthopaedics</u>, Vol. 29, No 6, pp. 430-434, 1994.
- 34. Marcus, R.E.; Pfister, M.E.; and Goodfellow. D.G.: The Difficult Diagnosis of Posterior Tibialis Tendon Rupture in Sports Injuries, <u>Orthopaedics</u>. Vol. 18, No. 8, pp. 715-721, 1995
- 35. Goodnough, L.T.; Verbrugge. D.; and Marcus, R.E.: The Relationship Between Hematocrit, Blood Lost and Blood Transfused in Total Knee Replacement, <u>The American Journal of</u> <u>Knee Surgery</u>. Vol. 8, No. 3. pp. 83-87, 1995.
- 36. Tisdel. C.L.; Marcus, R.E.; and Heiple, K.G.: Triple Arthrodesis for Diabetic Peritalar Neuroarthropathy, Foot and Ankle International, Vol. 16, No. 6, pp. 332-338, 1995.
- 37. Yue. J.J.; and Marcus, R.E.: The Role of Internal Fixation in the Treatment of Jones Fractures in Diabetics, Foot and Ankle International, Vol. 17, No. 9, pp. 559-562, 1996.
- Yue, J.J.; Wilber J.H.; Lipuma. J.P.; Murthi, A.; Carter, J.R.; Marcus, R.E.; and Valentz, R.: Posterior Hip Dislocations: A Cadaveric Angiographic Study, <u>The Journal of Orthopaedic</u> <u>Trauma</u>, Vol. 10, No. 7, pp. 447-454, 1996.

- 39. Victoroff, B.N.; Marcus, R.E.; and Deutsch, A.: Arthroscopic Bone Peg Fixation in the Treatment of Osteochondritis Dissecans in the Knee, <u>Arthroscopy: The Journal of Arthroscopic and Related Surgery</u>, Vol. 12, No. **4**, pp. 506-509, 1996.
- 4G. Goodnough, L.T.; and Marcus, R.E.: 'The Erythropoietic Response to Erythropoietin in Therapy in Patients With Rheumatoid Arthritis, Journal of Laboratory and Clinical Medicine. Vol. 130, pp. 381-386, 1997.
- 41. Marcus, R.E.: Practical Biomechanics: Intramedullary Fixation Devices. <u>Techniques in</u> <u>Orthopaedics</u>, Vol. 13, No. 1, pp. 1-8, January 1998.
- 42. Goodnough, L.T.; and Marcus, R.E.: Erythropoiesis in Patients Stimulated with Erythropoietin: The Relevance of Storage Iron. <u>Vox Sanguinis</u>, Vol. 75, pp. 128-133, 1998.

### **Published Books**

- 1. <u>Trauma in Children</u>, by R.E. Marcus, ed., 288 pages, Maryland: Aspen, 1986.
- 2. <u>Orthopaedics: Problems in Primary Care</u>, by R. E. Marcus, **400** pages, Los Angeles, P.M.I.C., 1991.

#### Visiting Professorships and Invited Lectureships

- 1. Hospital for Joint Diseases, Department of Orthopaedics, New York University School of Medicine. New York, N.Y., October 1989.
- 2. University of Cincinnati Medical Center, Department of Orthopaedics, Cincinnati, Ohio, October 1993.
- 3. Albert Einstein Medical Center, Department of Orthopaedics, Philadelphia, Pennsylvania, October 1993.
- 4. Louisiana State University School of Medicine, Department of Orthopaedics, New Orleans, Louisiana, Redler Lectureship, November 1994.
- **5.** Nippon University School of Medicine, Department of Orthopaedics, Tokyo, Japan, July 1995.
- 6. Hirosaki University School of Medicine, Department of Orthopaedics, Hirosaki, Japan, July 1995.
- Japan Fracture Repair Society, 21st Annual Meeting, Special Guest Lecture, Osaka, Japan, July 1995.

- 8. International Seminar for Fracture Treatment, Guest Lecturer, Department of Orthopaedic Surgery, Osaka City University Medical School, Osaka, Japan, July 1995.
- 9. Greenville Medical Center, Department of Orthopaedics, Greenville, South Carolina, November 1995.
- 10. University of California Irvine, Department of Orthopaedics, Irvine, California, January 1996.
- 11. Tempie University, Department of Orthopaedics, Philadelphia, Pennsylvania, December 1996.
- 12. Emory University, Department of Orthopaedics, Atlanta, Georgia, January 1997.
- 13. Royal College of Physicians and Surgeons of Canada, Guest Speaker, Hospital du Sacré Coeur, Montreal, April 1997.
- 14. Vanderbilt University, Department of Orthopaedics, Nashville, Tennessee, June 1997.
- 15. Australian Orthopaedic Association Keynote Speaker, High Energy Trauma Conference. Melbourne, Australia, August 1997.
- 16. Hennepin County Medical Center Annual Orthopaedic and Trauma Seminar Guest Speaker, Minneapolis, Minnesota, October 1997.
- 17. Inchon Kil Hospital. Department of Orthopaedics, Inchon, Korea, December 1998.
- 18. Ewha Women's University, Mokong Hospital, Department of Orthopaedic Surgery, Seoul. Korea. December 1998.
- 19. Tn-Service General Hospital National Defence Medical Center, Department of Orthopaedics. Taipei, Taiwan, Republic of China, December 1998.
- 20. Armed Forces Taoyuan General Hospital, Department of Orthopaedic Surgery, Taoyuan. Taiwan. Republic of China, December 1998.
- 21. Chungshan Medical College. Department of Orthopaedic Surgery, Taichung, Taiwan, Republic of China. December 1998.
- 22. ChiMei Hospital, Department of Orthopaedic Surgery, Tainan, Taiwan, Republic of China, December 1998.
- 23. National Police Medical Center, Department of Orthopaedics, Bangkok, Thailand, December 1998.

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- 24, Mahidol University, Siriraj Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 25. Royal Thai Airforce Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 26. Lerdsin General Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 7. All-India Institute of Medical Sciences, Department of Orthopaedics, New Delhi, India, December 1998.
- 28. Hosmat Hospital, Department of Orthopaedics Trauma Symposium, Bangalore, India, December 1998.

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### Presentations to Local, National, and International Medical and Scientific Societies

- 1. The Metabolic Response to Trauma. The Swiss Institute for Surgical Research, Davos, Switzerland, March 1981.
- 3. Internal Fracture Fixation Techniques. Northeast Ohio Chapter of the National Association of Orthopaedic Nurses, Fall Meeting, Cleveland, Ohio, October 1981.
- 3. The Relationship of Ketone Metabolism in Traumatic Injury. Grand Rounds, Department of Surgery. Case Western Reserve University School of Medicine, Cleveland, Ohio, December 1981.
- 4. The Multiply Injured Child of Adolescent: The Case Western Reserve Experience. The Forty-Ninth Annual Meeting of the American Association of Orthopaedic Surgeons, New Orleans. Louisiana. January 1982.
- 5. The Orthopaedic Management of the Child with Neurologic Injury. The European-American Winter Neurosurgery Conference, Obergurgle, Austria, March 1982.
- 6. Closed Intramedullary Nailing of the Femur, Orthopaedic Grand Rounds Conference, The Mount Sinai Medical Center, Cleveland. Ohio. May 1982.
- 7. 1982 Concepts in Fracture Management. "Medicine Today" 1982, Case Western Reserve University School of Medicine. Cleveland, Ohio, May 1982.
- 8. The Management of Pelvic Fractures. Trauma Update, 1982, Case Western Reserve University School of Medicine, Cleveland, Ohio, May 1982.
- 9. Faculty AO/ASIF, Advanced Course on the Operative Treatment of Fractures and Nonunions. sponsored by the Johns Hopkins School of Medicine, Hot Springs, Virginia, April 1983.

- 10. Railyard Amputations in Children. The Association of Children's Prosthetic and Orthotic Clinics Annual Meeting, Salt Lake City, Utah, May 1983.
- 11. The Management of Fractures Associated with Vascular Trauma, Trauma Symposium, Case Western Reserve University School of Medicine, Cleveland, Ohio, June 1983.
- 12. Intramedullary Nailing: Variations on a Theme. Orthopaedic Grand Rounds Conference, Saint Luke's Hospital, Cleveland, Ohio, July 1983.
- 13. Orthopaedic Methods in Trauma, Radiology Grand Rounds, Case Western Reserve University School of Medicine, Cleveland, Ohio, November 1983.
- 14. Closed Intramedullary Nailing Techniques, Orthopaedic Grand Rounds, Touro Infirmary, New Orleans, Louisiana, February 1984.
- 15. Metabolic Response to Trauma in Adults. The European-American Neurosurgical Society, St. Moritz, Switzerland, March 1984.
- 16. Multiple Injury in Children. Tulane Caldwell Society Annual Meeting, New Orleans. Louisiana, May 1984.
- 17. Interlocking Intramedullary Nailing Techniques, Trauma Symposium, Sponsored by the Department of Orthopaedics, Case Western Reserve University, Cleveland, Ohio, August 1984.
- Faculty AO/ASIF Basic Course on the Operative Treatment of Fractures and Nonunions, Sponsored by the University of South Florida School of Medicine, Pheasant Run Resort, Illinois. September 1984.
- 19. A.O. Techniques in Fracture Management, Tulane University School of Medicine, Department of Orthopaedics, New Orleans, Louisiana, September 1984.
- 20. Chevron Ankle Arthrodesis, Louisiana Orthopaedic Association Annual Meeting, New Orleans, Louisiana, October 1984.
- 21. Pre-Operative User of Providine-Iodine: A Prospective Randomized Study, The Fifty-Second Annual Meeting of the American Academy of Orthopaedic Surgeons, Las Vegas, Nevada, January 1985.
- 22. Faculty AO-ASIF Basic Course on the Operative Treatment of Fractures and Nonunions, sponsored by the Swiss Association for the Study of Internal Fixation, Lake Buena Vista, Florida, September 1985.
- 23. Techniques of Internal Fixation in Fractures and Nonunions, Tulane University School of Medicine, Department of Orthopaedics, New Orleans, Louisiana, October 1985.

- 24. New Techniques of Closed Intramedullary Nailing, Case Western Reserve University School of Medicine, Orthopaedic Grand Rounds, May 1986.
- 25. Faculty AO/ASIF Advanced Course on the Operative Treatment of Fractures and Nonunions. sponsored by the Swiss Association for the Study of Internal Fixation, Davos, Switzerland, December 1986.
- 26. Closed Lnterlocking Intramedullary Nailing of Long Bone Fractures, Herndon Society Biannual Meeting, Palm Beach, Florida, April 1987.
- 27. Chevron Technique for Ankle Arthrodesis, International Meeting of the Girdlestone Society. Nuffield Department of Orthopaedic Surgery, Oxford University, Oxford, England, September 1987.
- 28. MRI Gadolinium Evaluation of the Lumbar Spine, European American Neurosurgical Society, International Meeting, Vienna, Austria, March 1988.
- 29. Faculty AO/ASIF Techniques: Aims, Principles and Instrumentation of AO/ASIF, Cleveland Clinic, Cleveland, Ohio, July 1988.
- 30. Management of Shoulder Problems, University Hospitals of Cleveland, Department of Physical Therapy Seminar, Cleveland. Ohio, September 1988.
- 31. Unipolar Femoral Head Replacement Following Fractures, Orthopaedic Trauma Association, Dallas, Texas, October 1988.
- 32 Comparison of Bipolar and Austin Moore Replacement for Fractured Femoral Necks in the Elderly, Herndon Orthopaedic Society Biannual Meeting, Snowmass, Colorado. April 1989.
- 33 Unipolar Vs. Bipolar Hip Replacements, Grand Rounds, Hospital for Joint Diseases, Department of Orthopaedics, New York University School of Medicine, New York, N.Y., October 1989.
- 34. Don't Throw Away the Austin Moore, American Academy of Orthopaedic Surgeons' 57th Annual Meeting, New Orleans, Louisiana, February 1990.
- 35 Difficult Tibial Shaft Fractures, Zimmer Trauma Course on Upper and Lower Extremity Complex and Difficult Fracture issues. Amelia Island, Florida, December 1990.
- *36.* Intramedullary Nailing of Complex Tibial Fractures, Herndon Orthopaedic Society Biannual Meeting, Montego Bay, Jamaica, January 1991.
- 37. Erythropoietin in Surgical Anemias, Department of Medicine Postgraduate Course, Case Western Reserve University School of Medicine, Cleveland, Ohio, March 1991.
- 38. Design and Use of Intramedullary Nails, Michigan Orthopaedic Society, Bloomfield Hills, Michigan, April 1991.

- 39. Plate Fixation of Fractures: Theory and Technique, Grand Rounds, Department of Orthopaedics. Case Western Reserve University School of Medicine, Cleveland, Ohio, June 1991.
- 40. Treatment of Hip Fractures, Grand Rounds, Department of Orthopaedics, Case Western Reserve University School of Medicine, Cleveland, Ohio, September 1991.
- 41. Treatment of Complex Tibia Fractures, Youngstown Orthopaedic Surgeons' Fall Meeting, Youngstown, Ohio, September 1991.
- 42. Treatment of Fernoral Neck Fractures, Department of Orthopaedics, Ground Rounds, Mt. Sinai Medical Center, Cleveland, Ohio, July 1992.
- 43. Indications. Techniques and Results of Intramedullary Nailing of Femoral and Tibial Fractures. Maryland Shock Trauma Hospital, Trauma Meeting, Baltimore, Maryland, August 1992.
- 44. The Use of Intramedullary Fixation for Complex Femoral and Tibial Fracture, Department of Orthopaedic Surgery, Columbia University College of Physicians and Surgeons. Trauma Course. New York, New York, October 1992.
- 45. Technique and Complications in Intramedullary Nailing of the Femur, Management of Complex Fracrures Course, Richard F. Kyle, M.D., Chairman, Vail, Colorado, January 1993.
- 46. The Effect of Erythropoietin Therapy in Red Blood Cell Volume Expansion in Autologous Blood Donors Undergoing Elective Orthopaedic Surgery, American Academy of Orthopaedic Surgery, San Francisco, California, February 1993.
- 47. Complex Femoral and Tibial Nailings, American Osteopathic Academy of Orthopaedics. 33rd Annual Postgraduate Seminar, Scottsdale, Arizona. April 1993.
- 48. Complications of Femoral Shaft Fractures, San Diego Course in Management of Complex Fractures, San Diego, California, June 1993.
- 49. Knee Injuries. Evaluation and Treatment, Cleveland Academy of Trial Attorneys, Cleveland. Ohio, September 1993.
- 50. Hip Fractures. Orthopaedic Grand Rounds, Department of Orthopaedics, Case Western Reserve University, Cleveland, Ohio. October 1993.
- 51. Complications of Intramedullary Nailing, Orthopaedic Grand Rounds, Department of Orthopaedics, University of Cincinnati, Cincinnati, Ohio, October 1993.
- 52. Techniques of Intramedullary Nailing, Orthopaedic Grand Rounds, Department of Orthopaedics, The Toledo Hospital, Toledo, Ohio, October 1993.

- 53. Complications of Intramedullary Nailing, Orthopaedic Grand Rounds, Department of Orthopaedics. Albert Einstein Medical Center, Temple University School of Medicine, Philadelphia, Pennsylvania, October 1993.
- 54. Technique of Intramedullary Nailing, Course in the Management of Complex Fractures, Problems and Solutions, Robert A. Winguist, M.D., Chairman, Amelia Island, Florida, December 1993.
- 55. Cementless Total Knee Arthroplasty for Osteoarthritis: A Five to Nine Year Functional and Radiological Outcome Study, Goldberg V.M., Buly R.L. and Marcus R.E., American Academy of Orthopaedic Surgeons' 61st Annual Meeting, New Orleans, Louisiana, February 1994.
- 56. Treatment of Subtrochanteric Fractures of the Femur, Symposium on New Concepts in Long Bone Fracture Fixation, David Templeman, M.D., Chairman, Houston, Texas, May 1994.
- 57. The Use of Ceramic Unipolar Arthroplasty in the Treatment of Hip Fractures, The Seventh Irving Redler M.D. Orthopaedic Memorial Lecture Touro Infirmary, New Orleans, Louisiana, November 1994.
- 58. Complications of Intramedullary Nailing, Orthopaedic Grand Rounds, Louisiana State University School of Medicine, New Orleans, Louisiana, November 1994.
- 59. Biomechanics of I.M. Nailing, 3rd Annual Management of Complex Fractures Problems and Solutions. Richard F. Kyle, M.D., Chairman, Vail, Colorado, January 1995.
- 60. Design of Intramedullary Fixation Devices, Zimmer Canada National Meeting, Toronto, Canada. February 1995.
- 61. Ceramic Unipolar Hip Replacement in the Treatment of Femoral Neck Fractures, Orthopaedic Grand Rounds. St. Luke's Hospital, Cleveland, Ohio, February 1995.
- 62. Design of a Unipolar Ceramic Hip, Charles Herndon Orthopaedic Society Biannual Meeting, St. Croix, U.S.V.I., March 1995.
- 63. Biomechanics of I.M. Nails, Cleveland Trauma Update, Randall E. Marcus, M.D., Chairman. Cleveland. Ohio, April 1995.
- 64. Bone Grafting in Revision Total Hip Surgery, Hip and Knee Revision Seminar, Department of Orthopaedics, University of California. Davis, California, April 1995.
- 65. Outcome of 100 Consecutive Cementless Femoral Components; Minimal 5-Year Follow-Up, Goldberg, V.M., Kraay, M., Marcus, R.E., 108th Annual Meeting of the American Orthopaedic Association, White Sulphur Springs, West Virginia, June 1995.

- 66. Results of a Cementless Total Knee Arthroplasty with a Cemented Congruent Patella, Goldberg, V.M., Kraay, M., Marcus, R.E., 108th Annual Meeting of the American Orthopaedic Association, White Sulphur Springs, West Virginia, June 1995.
- 67. Design and Biomechanics of Intramedullary Fixation Devices, Orthopaedic Grand Rounds. Nippon University Medical Center. Tokyo, Japan, July 1995.
- 68. Design and Biomechanics of Intramedullary Fixation Devices, Orthopaedic Ground Rounds. Hirosaki University Medical Center, Hirosaki, Japan, July 1995.
- 69. Treatment of Open Fractures of the Tibia, Special Lecture, The 21st Annual Meeting of the Japan Fracture Society, Osaka, Japan. July 1995.
- 70. Complications of Intramedullary Nailing of the Femur, International Seminar for Fracture Treatment. Osaka, Japan, July 1995.
- 71. Technique of Femoral Shaft Intramedullary Nailing and Proximal Femur Reconstructive Nailing. Orthopaedic Trauma Association Residents Fracture Course, Tampa, Florida, September 1995.
- 72. Biomechanics of Intramedullary Devices, Orthopaedic Grand Rounds, Greenville Memorial Medical Center. Greenville, South Carolina, November 1995.
- Design and Biomechanics of Intramedullary Fixation Devices, Orthopaedic Grand Rounds, Depanment of Orthopaedics. University of California Irvine, Irvine, California, January 1996
- 74. Biomechanics of I.M. Nailing, 10th Annual Vail Orthopaedic Symposium, Richard Kyle, M.D., Chairman, Vail, Colorado, January 1996.
- 75. Clinical Applications and Techniques in the Treatment of Open Tibia Fractures and Biomechanics Design Considerations of the ZMS Nail System, Trauma Symposium, Division of Orthopaedics, Dalhousie University, Halifax, Nova Scotia, 1996.
- 76. Complications of Intramedullary Nailing and Intramedullary Fixation Devices -Biomechanics, Trauma Update, University of Southern California, Jackson Lee, M.D., Chairman. Dana Point. California, June 1996.
- 77 Oxidized Zirconium for Hemiarthroplasty, Orthopaedic Grand Rounds. Case Western Reserve University School of Medicine, Cleveland, Ohio, July 1996.
- 78 Biomechanics of Intramedullary Nails, Orthopaedic Grand Rounds, St. Luke's Medical Center, Cleveland, Ohio, August 1996.
- 79. Techniques of Femoral Shaft Nail Fixation, Orthopaedic Trauma Association Residents' Basic Fracture Course, Boston, Massachusetts, September 1996.

- 80. Reamed vs. Unreamed Nails Biomechanics, International Trauma Update, Robert Winquist, M.D., Chairman, Phoenix, Arizona, November 1996.
- 81. Soft Tissue Management of Open Fractures, Western Reserve Care System Department of Surgery Grand Rounds, Youngstown. Ohio. November 1996.
- 82. Design and Biomechanics of Intramedullary Nails, Orthopaedic Grand Rounds, Temple University School of Medicine, Philadelphia. Pennsylvania, December 1996.
- 83. Biomechanics of Intramedullary Fixation Devices, Orthopaedic Grand Rounds, Emory University School of Medicine, Atlanta, Georgia, January 1997.
- 84. Biomechanics of I.M. Nailing, Trauma Update, 11th Annual Vail Orthopaedic Symposium, Richard Kyle, M.D., Chairman, Vail, Colorado, January 1997.
- 85. Management of Lower Extremity Trauma and Soft Tissue Injuries; Biomechanics and Design of Intramedullary Fixation Devices; Technique of Reconstructive Intramedullary Nailing; Guest Speaker of the Royal College of Physicians and Surgeons of Canada, "Les Journées de Traumatologie," Hospital du Sacré Coeur, Montreal, Canada, April 1997.
- 86. Soft Tissue Management in Open Fractures; Indirect Reduction in Fracture Fixation, International Trauma Update, T.A. Russell, M.D., Chairman, Maui, Hawaii, April 1997.
- 87 Treatment Failure in Femoral Neck Fractures in Patients 80 Years of Age and Older, 49th Annual Meeting of the Association of Bone and Joint Surgeons, Scottsdale, Arizona, May 1997.
- 88 Indirect Reduction Techniques in Fracture Fixation, Orthopaedic Grand Rounds, Greenville Medical Center. Greenville, South Carolina. May 1997.
- 89 Biomechanics of Intramedullary Fixation Devices, Department of Orthopaedics, Vanderbilt University School of Medicine, Nashville, Tennessee, June 1997.
- 90 Biomechanics and Design of Intramedullary Nails, Grand Rounds, Department of Orthopaedics, Case Western Reserve University School of Medicine. Cleveland, Ohio, June 1997.
- 91 Priorities and Guidelines in Managing the Multiple Trauma Patient; Status of Intramedullary Rods in Acute Trauma in the Femur; Who Deserves Amputation; Talus Fractures and Dislocations. Operative Management, Results and Complications; Australian Orthopaedic Association High Energy Trauma ,Meeting, Melbourne, Australia, July 1997.
- 92 Biomechanics of Intramedullary Fixation: Complex Fractures of the Distal Femur: Indirect Reduction Techniques; Current Treatment of Talus Fractures; Hennepin County Medical Center Annual Orthopaedic and Trauma Seminar, Minneapolis, Minnesota, October 1997.

- 93. Percutaneous Pin Fixation of Proximal Humeral Fractures, Orthopaedic Trauma Association Annual Meeting, Louisville, Kentucky, October 1997.
- 94. Technique of Reconstructive Intramedullary Nailing of the Femur, Orthopaedic Trauma Association Residents' Basic Fracture Course. Louisville. Kentucky. October 1997.
- 95. Diabetic Charcot Arthropathy, Case Western Reserve University School of Medicine, University Hospitals Multidisciplinary Symposium, Salvaging the Diabetic Foot, Cleveland, Ohio. October 1997.
- 96. Charcot Foot Deformity, Multidisciplinary Symposium Salvaging the Diabetic Foot, Sponsored by the Divisions of Endocrinology and Vascular Surgery, University Hospitals of Cleveland and Case Western Reserve University School of Medicine, October 1997.
- 97. Femoral Fractures in Children; Open Reduction Internal Fixation of Proximal Humeral Fractures; Management of Fractures of the Talus; Trauma Update, 12th Annual Vail Orthopaedic Symposium, Richard Kyle, M.D., Chairman, Vail, Colorado, January 1998.
- 98. Intramedullary Nailing of the Femur; Instructional Course Lecture (216), American Academy of Orthopaedic Surgeons, 65th Annual Meeting, New Orleans, Louisiana, March 1998.
- 99. Modified McBride Procedure: Unpredictable Results as Treatment for Hallux Valgus; Outcome Study of Tibiotalar Arthrodesis by the Chevron Fusion Technique; 50th Annual Meeting of the Association of Bone and Joint Surgeons, Aspen, Colorado, June 1998.
- 100. Ceramic Unipolar Prosthesis for the Treatment of Displaced Femoral Neck Fractures in the Elderly, Annual Meeting of the Girdlestone Orthopaedic Society of Oxford University, Grarz. Austria, August 1998.
- 101. Hallux Valgus: What Works and What Doesn't, The President's Guest Lecture, Cleveland Orthopaedic Society, Cleveland. Ohio, October 1998.
- 102. Intramedullary Nailing of Femoral Shaft Fractures, Orthopaedic Trauma Association Residents' Basic Fracture Course, Vancouver, Canada, October 1998.
- 103. Update Knowledge Intramedullary Nailing Design and Biomechanics, Inchon Kil Hospital, Department of Orthopaedics, Inchon. Korea, December 1998.
- 104. Biomechanics of Intramedullary Nailing, Ewha Women's University, Mokong Hospital, Department of Orthopaedic Surgery, Seoul, Korea, December 1998.
- 105. Biomechanics, Design and Decision-Making in Intramedullary Nailing of the Femur, Tri-Service General Hospital National Defence Medical Center, Department of Orthopaedics, Taipei, Taiwan, Republic of China, December 1998.

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- 106. Biomechanics of Intramedullary Nailing, Armed Forces Taoyuan General Hospital, Department of Orthopaedic Surgery, Taoyuan, Taiwan Republic of China, December 1998.
- 107. Soft Tissue Management of Open Fractures, Chungshan Medical College, Department of Orthopaedic Surgery, Taichung, Taiwan, Republic of China, December 1998.
- 108. Biomechanics and Technique of Intramedullary Fixation, ChiMei Hospital, Department of Orthopaedic Surgery, Tainan, Taiwan, Republic of China, December 1998.
- 109. Complications, Design and Technique of Intramedullary Nailing, National Police Medical Center, Department of Orthopaedics, Bangkok, Thailand, December 1998.
- 110. Biomechanics and Design of Intranedullary Fixation Devices, Mahidol University, Siriraj Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 111. Biomechanics Knowledge Update, Intramedullary Nailing, Royal Thai Airforce Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 112. Techniques for Extraction of Broken Intramedullary Nails, Lerdsin General Hospital, Department of Orthopaedic Surgery, Bangkok, Thailand, December 1998.
- 113. Biomechanics and Design of Intramedullary Nails; Indirect Reduction Techniques for Intra-Articular Fractures, All-India Institute of Medical Sciences, Department of Orthopaedics, New Delhi, India, December 1998.
- 114. Complications and Pitfalls of Intramedullary Nailing of the Femur, Hosmat Hospital, Department of orthopaedics Trauma Symposium, Bangalore, India, December 1998.
- 115. Lisfranc Dislocations; Biomechanics of Intramedullary Rods; Indirect Reduction of the Femur; Trauma Update, 13th Annual Vail Orthopaedic Symposium, Richard Kyle, MD, Chairman. Vail. Colorado, January 1999.
- 116. Clavicle Fractures Classification and Complications; Fractures of Both Bones of the Forearm: Upper Extremity: Problem Fractures and Reconstructive Challenges, Thomas Varecka, MD, Chairman, Vail. Colorado, January 1999.

### **TEACHING AWARDS**

Case Western Reserve University Department of Medicine Ambulatory Medicine Teaching Excellence Award, 1996-1997

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